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ABSTRACT

Pursuant to the mission of the University of Minnesota's Mental Health Technical Assistance Center for the state refugee assistance programs, this report presents models of culturally sensitive training for professional and paraprofessional personnel who provide mental health service to refugees. After an introduction which places this report in the context of other activities of the Technical Assistance Center and describes the process of developing models of refugee mental health training, specific models of culturally sensitive education and training are provided for the following human service professions: (1) social work; (2) psychiatry; (3) psychology; (4) nursing; (5) allied health professions; (6) human service generalist programs; and (7) primary health care providers. Two final sections discuss the issue of interpreting in refugee mental health and the credentialing of refugee mental health personnel. Twenty attachments, including summary reports and descriptions of various degree and training programs, course syllabi, and concept papers are appended. (TE)

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REFUGEE ASSISTANCE PROGRAM - MENTAL HEALTH:

TECHNICAL ASSISTANCE CENTER

TASK VI - TRAINING

MODELS OF PROFESSIONAL AND PARAPROFESSIONAL TRAINING IN REFUGEE MENTAL HEALTH

March, 1988

NIMH Contract #278-85-0024 (CH)

CG 021748

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MODELS OF PROFESSIONAL AND PARAPROFESSIONAL TRAINING IN REFUGEE MENTAL HEALTH

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The report has been prepared in accordance with the terms of the contract between the Technical Assistance Center and the National Institute of Mental Health (Contract #278-85-0024 (CH)) to provide consultation and technical assistance to the state Refugee Assistance Programs - Mental Health.

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UNIVERSITY OF MINNESOTA
REFUGEE ASSISTANCE PROGRAM - MENTAL HEALTH
TECHNICAL ASSISTANCE CENTER

MODELS FOR PROFESSIONAL AND PARAPROFESSIONAL TRAINING IN REFUGEE MENTAL HEALTH

INTRODUCTION

As part of the refugee mental health initiative of the National Institute of Mental Health and the Office of Refugee Resettlement, the Technical Assistance Center is responsible for providing technical assistance and consultation to the state Refugee Assistance Programs-Mental Health on culturally-sensitive training for professional and paraprofessional personnel and others who provide mental health services to refugees. This report on models of culturally-sensitive training in refugee mental health has been prepared in partial fulfillment of that responsibility.

This report is directed primarily to the pre-service training of the "core" mental health professionals (psychiatrists, psychologists, social workers, and nurses) and other professional and paraprofessional personnel who provide mental health services to refugees. Such training is aimed at increasing the number of trained staff who are able to provide culturally-sensitive mental health services to refugees by incorporating cross-cultural content into the curricula of university and college degree-granting professional schools and programs.

In addition to the four "core" mental health professions--psychiatry, psychology, social work, and nursing--other professional

and occupational groups are involved in mental health in general and refugee mental health in particular, for example: primary health care providers such as family practice physicians, internists, pediatricians, nursing practitioners, and community nurses; "human service generalists" who usually are graduates of two-year associate degree programs; primary and secondary school teachers who come into contact with refugee children and youth and who often are the first to detect mental health problems in refugee families; public assistance workers who routinely encounter refugees because of the high welfare dependency rate among refugees; employment counselors; public housing staff; ESL teachers; and the allied health professions such as occupational and physical therapists who serve refugees in medical and mental health settings. Many nonclinical disciplines are interested in refugees and refugee mental health in research, planning, and management roles, for example, sociology, anthropology, linguistics, public affairs, and management. This report focuses mainly on models of training for the "clinical" mental health professions with some attention given to the allied health professions and mental health-related disciplines.

A second area of training with which the Center is concerned is in-service training of mental health professionals and paraprofessionals employed in refugee-serving mental health agencies. Such training is aimed at the immediate needs of mental health agencies for training of currently employed staff to enable them to reach and provide refugees with culturally-sensitive, effective mental health services. This area of training is addressed in a previously distributed Center report, CULTURALLY-SENSITIVE REFUGEE MENTAL HEALTH

TRAINING PROGRAMS, dated 15 April 1987, which describes a number of agency-based in-service training programs.

The agency-based training programs for employed staff described in the above-cited report are of two general kinds:

1. Agency-based "home grown" training programs are designed, organized and conducted primarily by and for the agency's own staff or constituency. Two examples of this approach described in the report are those of the Community University Health Care Center (CUHCC), Minneapolis, (See Attachment A) and the Wilder Refugee Social Adjustment Program, (See Attachment B). Both agencies employ bilingual refugee paraprofessionals as front-line workers. In both agencies, the training for the paraprofessionals, professionals, and community leaders was conducted mostly by the agencies' own staff together with consultants from the local professional community.

2. Agency-based "contracted" training programs are those in which the provider agency contracts with an individual expert, an institute, a national organization or a university or college to plan and conduct the training. A number of such programs were described, for example: those of the Spring Institute, Colorado; the American Refugee Committee; The U. S. Catholic Conference, Lutheran Immigration and Refugee Service, and the U. S. Office of Refugee Resettlement Conference on Unaccompanied Minors; and the training provided by Tedla W. Giorgis, Ph.D., an expert on Ethiopian refugees.

Much of the content of the training programs described in that report is directly transferable to other agency-based and university-based professional and paraprofessional training in refugee mental health. The report is being periodically updated as additional

university and agency training programs that incorporate cross-cultural or refugee content are identified.

An important part of agency staff development is continuing education for employed professionals. Continuing education is often provided through special departments of university and college professional schools and programs and is included among the models of training for the various professions and disciplines discussed in this report.

This report should be seen in relation to other activities of the Technical Assistance Center and the state refugee assistance programs, particularly as they relate to training. The literature has been searched and an extensive annotated bibliography on refugee mental health, including references on training, has been compiled and distributed. (Carolyn L. Williams, An Annotated Bibliography on Refugee Mental Health. Washington, D.C: National Institute of Mental Health, 1987) The state refugee assistance programs' refugee mental health needs assessments have found a number of barriers to service in the refugee mental health delivery system, among which is the need for training of bilingual professional and paraprofessional refugee staff and nonrefugee "American" professional and paraprofessional staff. A directory is being compiled of refugee and other mental health professionals available for employment in refugee-serving agencies. During site visits to identify successful, culturally-sensitive refugee mental health programs, Center teams have identified a number of effective training programs as well since the success of service programs is very largely a function of their training programs. (See

Attachment C for a brief fact sheet on the Technical Assistance Center.)

A directory is being compiled of sites and agencies in which students might be placed for field experiences in refugee mental health (that is, for field instruction, internships, practica, research, and observation) in connection with the students' training in a university or college professional school or program. A clinical field experience of some kind is an integral part of the training of any professional. Indeed, many mental health agencies that serve refugees are already deeply engaged in providing clinical practice experiences.

MODEL-BUILDING IN REFUGEE MENTAL HEALTH TRAINING

The process of developing models of refugee mental health training involved a number of steps that culminated in the various models of training presented in this report.

Step One.--The preparation of a background statement that summarizes the characteristics, experiences, resettlement problems, and mental health problems of refugees in the U.S. Training programs for personnel who will provide mental health services to refugees must take into account the culture, experiences, socioeconomic characteristics, and resettlement and adjustment problems of refugees as well as the cultural differences and different perceptions of health and mental illness between refugees and western mental health providers. This statement was developed for the report, CULTURALLY-SENSITIVE REFUGEE

MENTAL HEALTH TRAINING PROGRAMS, and is attached to this report as Attachment D.

Step Two.--The preparation of summary models of typical training programs and curricula for the several professions and disciplines that are engaged in refugee mental health, in particular, for the core mental health professions--psychiatry, psychology, social work and nursing--and the allied health professions. The rationale for this step is that only as one has a model of the overall training program and curriculum for a particular profession (for example, for a psychiatry residency or a masters degree in social work program) can one develop models of refugee mental health training that can be fitted into the overall curriculum in some logical fashion. The givens of the overall curriculum will dictate what is possible and what is not, and where and in what form refugee mental health content might be incorporated into the overall curriculum. A reality of all professional training is that the programs are invariably tightly packed; for new content or courses to be introduced, something usually has to be taken out. Accreditation standards impose certain requirements on curricula that may encourage or require content on cultural differences. State licensing in some professions influences the training curricula or requires continuing education in the profession.

Step Three.--The development of a range of refugee-specific or refugee-related "models" of culturally-sensitive training that can be fitted into the overall training program or curriculum in some logical way. "Models" can include: 1) comprehensive "concentrations" or "sequences"; 2) courses and seminars, required or elective;

3) "modules" such as lectures, workshops, exercises, demonstrations, and projects; 4) joint degree programs and interdisciplinary programs as in psychiatry-anthropology and MSW-MPH programs; 5) fellowship programs as in medicine; and 6) continuing education.

With respect to implementation of the models, two steps will be involved:

1. The selection and adaptation of the various models to the particular situations and needs of individual schools and programs.

2. The development of the actual content of the models in the form of curricula, course syllabi, lecture outlines, case examples, reading material, bibliographies, teaching aids, and class and field exercises.

The Center will continue to refine the models and will be engaged in developing content for the various models including details of curricula, course content, teaching material, case examples, and reading lists.

The models of training presented in this report were derived inductively from two main sources: 1) descriptions of training programs and refugee mental health training content reported in the published and unpublished literature, and 2) descriptive data about training programs gathered through correspondence, telephone interviews, and site visits. The report, CULTURALLY-SENSITIVE REFUGEE MENTAL HEALTH TRAINING PROGRAMS, describes and discusses many of the training programs from which the models presented in this report were derived.

SOCIAL WORK

Social Work Curricula

Pre-service training for the profession of social work is governed by the Accreditation Standards of the Council on Social Work Education and includes two degree programs: the graduate Master of Social Work (MSW) program and the undergraduate Bachelor of Social Work (BSW) program.

The Master of Social Work program is a graduate degree program of two academic years (four semesters or six quarters) of class and field instruction following the baccalaureate. The curriculum must be made up of a core curriculum, usually completed in the first year, consisting of five required areas or sequences: human behavior and the social environment, social welfare policy and services, social work practice methods, research, and 900 hours of MSW-supervised field instruction. Following the core curriculum, the student elects a "concentration", normally completed in the second year, of class and field instruction related to the concentration. Field instruction usually is in a direct service agency with the student carrying a selected caseload of clients. If the student elects a concentration in some area of direct service, such as with families and children, his or her second year of field instruction will also be in a direct service agency. If a student elects a concentration in one of the "indirect" services, such as planning, policy analysis, community organization or management, his or her field placement might be in a corresponding position in an agency (for example, the planning and research unit of a state mental health department).

BSW programs are designed to provide the "foundation" of social work knowledge and skills, roughly equivalent to the MSW "core curriculum". BSW programs typically have two years of liberal arts study, including one or two social work courses, followed by two years of study in the social work major, including a practicum in a social service agency.

The Curriculum Policy Statement of the accrediting body, the Council on Social Work Education, requires that both MSW and BSW curricula must provide content on ethnic minorities of color and women, other special population groups relevant to the program's mission or location and, in particular, groups that have been consistently affected by social, economic and legal bias and oppression. (Council on Social Work Education, Curriculum Policy for the Master's Degree and Baccalaureate Degree Programs, 1984.)

Accreditation standards are explicit with respect to cross-cultural content (for example, Evaluative Standard 13 of the Handbook of Accreditation Standards and Procedures, 1984, requires "...specific, continuous efforts to assure the enrichment of the educational experience...by reflecting racial, ethnic, and cultural diversity through the curriculum, including the field practicum and ...content incorporating diverse racial, ethnic, and cultural perspectives.") (Evaluative Standard 13, Council on Social Work Education, Handbook of Accreditation Standards and Procedures, 1984.) Thus, with respect to both MSW and BSW curricula, there are opportunities for the introduction of cross-cultural and refugee mental health content in the liberal arts component, in the social work major, and in the practicum.

In addition to the BSW and MSW social work programs, many schools of social work have doctoral programs that offer either the PhD or DSW degrees. Both, however, are research and theory-building programs and generally are not aimed directly at the development of direct service skill. However, research can be and is concerned with refugees and refugee mental health and a number of dissertations on refugees and refugee mental health have been produced.

Although two-year associate of arts programs are considered "human services" programs, many are social work-based and their faculties include many social work instructors. Some "human service" programs are, in fact, pre-social work programs. They are discussed later in this report in the section, HUMAN SERVICE GENERALIST PROGRAMS.

An MSW "Concentration" in Refugee Mental Health

This model of social work refugee mental health training is based on the core curriculum-concentration format of the MSW curriculum. The student entering this concentration would have completed the MSW core curriculum consisting of the five curriculum areas: social policy and social services, social work practice, research, human behavior and the social environment, and supervised field instruction in a direct service agency. In the human behavior sequence the student would have had a course or seminar on "cultural differences". Consequently, the student is assumed to have the equivalent of the BSW degree and is in advanced standing in some concentration.

A concentration in cross-cultural treatment or refugee mental health would be a second-year program of two semesters or three

quarters consisting of:

1. A social work policy and services seminar that would cover such content as: the refugee phenomenon, its magnitude and general characteristics; theories of refugee migration; demographics of refugees; refugee policies, including the UN protocols, and U.S. refugee laws and policies; the refugee experience, from pre-migration and flight to refugee camps and migration; resettlement; refugee resettlement programs; issues and problems in refugee resettlement; the refugee mental health and social service delivery systems; special provisions for refugee resettlement; refugee mutual assistance associations.

2. A social work practice methods seminar would provide instruction on treatment, diagnosis and prevention of refugee mental health problems and social adjustment taking into account the different refugee cultures, the refugee experience, resettlement problems and realities, the impact of acculturation, and such factors as racial discrimination and language and cultural barriers. Specific problems in diagnosis and treatment might include a consideration of the physical and mental trauma typically encountered by refugees and their implications for diagnosis and treatment; intergenerational conflict; role reversal and displacement, domestic violence, child abuse; and the diagnosis and treatment of typical refugee mental health problems such as depression. Overcoming language and cultural barriers includes not only recognition of cultural differences but use of interpreters and bilingual refugee paraprofessionals and the informal refugee support network of MAAs, natural helpers and traditional healers in outreach and treatment. The refugee mental health system is a complex

interrelated system of services and professionals; hence, practice instruction would include referral and collaboration with other mental health professionals such as psychiatrists, psychologists, and primary health care providers.

3. A practicum in a refugee-serving agency under MSW supervision would provide clinical experience with individual refugees and families, mutual assistance associations, traditional healers, and natural helpers. Since refugee-serving agencies necessarily employ bilingual staff, the student would have the experience of working through interpreters and with bilingual refugee paraprofessionals.

4. A number of social work and nonsocial work elective seminars or courses in such areas as immigration and acculturation theory in sociology, cross-cultural assessment in psychology, culture and cultural differences in anthropology, and immigration and naturalization policy in political science.

5. An integrative project or research thesis on some aspect of refugee policy, refugee resettlement, or social work practice with refugees.

The Howard University School of Social Work "Concentration in Displaced Persons", which includes refugees among displaced persons, might be an example for a social work "concentration". (See Attachment E.)

A Social Work Course on Refugees

A semester or quarter-length course or seminar on refugee mental health policy and practice could be offered as a free-standing elective

or be integrated with the practice, field, or policy areas of the curriculum. The course would be an introduction to the refugee phenomenon, the refugee experience, problems of migration and resettlement, refugee policy and programs, and consideration of the problems unique to providing refugees with mental health and social services given the special needs and problems of refugees and the language and cultural barriers to service. Methods of assessment and treatment would be considered, taking into account the adjustment and resettlement problems of refugees, the cultural differences, and the need to enlist the help of the informal refugee support network.

For students interested in work with refugees, the course or seminar should be premised on the students' placement in a refugee-serving agency for field instruction. For other students, the course would serve as a general introduction to refugees and other displaced populations and to cross-cultural social work practice. The course could be open to nonsocial work graduate students as well.

The Columbia University-Hunter College Schools of Social Work course on refugee mental health is an example of a social work course on refugees. (See Attachment F.)

A Social Work "Module" on Refugees

Modules can include lectures, workshops, exercises, field observations and experiences with refugees, simulations such as role playing,and audio-visual aids on refugees and refugee mental health. Modules are packages of refugee-specific content that can be incorporated into various courses or offered as free-standing offerings

to all students. Each module would provide relevant reading such as models, theories, case examples, articles, and reading lists.

For example, one "module" might be one or more class sessions taught by an instructor with competence in refugee mental health who could teach that content to a class in the "cultural differences" seminar as the class considers different races and cultures. A field instructor who works with refugees (for example, unaccompanied minors) in a family service agency, similarly could offer a special lecture or part of a practice methods course when the class is considering cross-cultural practice. A workshop or colloquium on various aspects of refugee mental health could be offered to all students and could include content on any of the curriculum areas: refugee resettlement policy and program, practice with refugees, refugee cultures and cultural differences, intergenerational conflict in refugee families, domestic violence and child abuse in refugees, or the informal support network in refugee communities.

Packaged "exercises" might be introduced (for example, role playing that simulated work with refugees on specific mental health problems, such as the changing role of women in refugee families; home visits to refugee families; a class discussion with an invited refugee; a videotape of an interview with a refugee.) Examplars of research on refugees might be packaged for use in research courses to illustrate research on refugees as well as on problems on research design and method and to illustrate such concepts as needs assessment, planning, policy development, and resource allocation.

Joint Degree and Cross-Disciplinary Social Work Programs

Joint degree and cross-disciplinary programs are common and are encouraged in social work education because the social work profession interacts with and draws from so many disciplines and fields of knowledge. Among the formal joint degree programs are those between social work and professional degree programs such as public health (MSW-MPH), public affairs (MSW-MPA), business administration (MSW-MBA), and law (MSW-JD). Minor programs and cross-disciplinary programs also are common (for example, the MSW degree and minors or cross-disciplinary studies in family social science, child development, anthropology, and sociology.) Thus, a joint degree or cross-disciplinary model of social work education could include cross-cultural and refugee mental health content in cultural anthropology or cultural aspects of child abuse in a school of public health.

Continuing Education in Social Work

Most graduate schools of social work have continuing education departments, either as an integral part of the regular program or as a component of a university continuing education division. Continuing education offerings of schools of social work range from regularly offered summer institutes and conferences to workshops, regular degree courses, and various training sessions for employed staff. Some continuing education departments are engaged in refugee mental health with a variety of offerings. An example of a more formally organized continuing education center for refugees is that of Boston University

School of Social Work, Continuing Education Department, Refugee and Immigrant Training Program. (See Attachment G.) The Center has its own director and staff and has offered training for bilingual refugee paraprofessionals, employed professionals, and current MSW students on various aspects of refugee mental health.

Social work continuing education programs are particularly responsive to the training needs of local agencies and staff since most are self-supporting from tuition from students and registrants and from contracts with local provider agencies. These departments also are in a position to tap the resources of both the universities and the local agencies for instructors. Two additional strengths of continuing education in social work programs might be noted: 1) They are part of the "mainstream" higher education system and their regular faculty and staff are members of the university faculty and staff; and 2) Continuing education credits earned in university and college programs often are transferable to regular degree programs.

PSYCHIATRY

Education in Psychiatry

Formal education of a psychiatrist begins in medical school, continues into residency and possibly fellowship training, and requires fulfillment of continuing education throughout the practitioner's career. The structure of formal training, from medical school through fellowship, combines didactic and clinical requirements. Ideally, the didactic and clinical experiences are carefully integrated, especially

on specialized subjects such as refugee mental health; otherwise there is relatively little impact on the practice of the trainees. (1) In addition, prolonged exposure and repetition has a greater impact on resident trainees. (2) Consequently, a focus on cultural issues or specific refugee cultural groups should begin early in medical training and continue throughout fellowship and into continuing education. Since it is virtually impossible to discuss every refugee group in detail throughout the learning experiences, it may be better to aim initially for basic cross-cultural sensitivity, awareness, and knowledge. Paradoxically, despite the fact that much more is known about cultural psychiatry and its importance to psychiatric practice, the competition with other rapidly growing areas of psychiatric knowledge for an adequate presentation during training has become intense. (3)

With respect to refugees and cultural issues, the following sections will discuss special requirements for training, review the didactic and clinical structure most appropriate at each level of training, and mention possible content areas to teach.

Medical Student Psychiatry Education

Admission to medical school generally requires a bachelor's level degree (B.A. or B.S.) and medical education takes approximately four years to complete the requirements for the M.D. degree. Structurally, medical school education usually emphasizes coursework during the first two years and subsequently shifts to clinical clerkships, each of approximately six weeks duration, during the last two years.

As Wyatt and others have commented, unless a medical school has a large student population of minorities, cultural issues are seldom included in the curriculum. (4) This is despite the recommendation by the American Psychiatric Association's Committee on Medical Student Education that students should know about "cultural aspects of behavior, especially values, expectations, and the unique problems of those cultural groups whom the student will be treating." (5)

In the early part of medical school, a course in "behavioral sciences" is usually required and, within this course, sensitivity to cultural issues, including those of refugees, can be introduced by selecting appropriate lectures and lecturers. In the clinical clerkships, case conferences to discuss patients could select a refugee in order to present unique diagnostic and treatment problems. Concurrent seminars or didactic lectures during the psychiatry clerkship could also include sociocultural issues, such as those of refugees. The most effective way to introduce diagnostic and treatment issues for refugees is pointing out these issues to students in the context of the evaluation and management of the refugee patient. Not always will a refugee patient be available, but the opportunity should be seized when available.

Psychiatry Residency Training

The psychiatry residency requires completion of the M.D. or D.O. degree and is usually of four years duration. The didactic and clinical curriculum, according to The Directory of Graduate Medical Education Programs (6), must provide for presentation of the generally

accepted theories, schools of thought and major diagnostic and therapeutic procedures, and must include a significant number of interdisciplinary clinical conferences and didactic seminars. Any approved psychiatry residency must have an explicitly described educational curriculum composed of 1) formal didactic instruction such as regularly scheduled seminars and required reading assignments and 2) clinical experiences in which the resident, under supervision, receives progressively greater responsibility for patient care. The residency must include at least one year in an outpatient program providing experiences with a wide variety of psychiatric disorders, patients, and treatment modalities, using both psychodynamic and biologic approaches. The didactic curriculum is required to include "appropriate material from the social and behavioral sciences" and "should provide its residents with instruction about American culture and subcultures". The Directory further states, "Many physicians may not be sufficiently familiar with attitudes, values, and social norms prevalent among various groups of contemporary Americans. Therefore, the curriculum should contain enough instruction about these issues to enable residents' cultural backgrounds to be examined. This course must be especially comprehensive in those programs with residents whose cultural backgrounds are significantly different from those of their patients." In addition, the American Association of Directors of Psychiatric Residency Training (AADPRT) stated in its 1984 Special Requirements that "the curriculum should . . . enable residents to render competent care to their patients from various cultural backgrounds" and that residents "must have supervised experience in

evaluation and treatment of patients . . . from a variety of ethnic, racial, social, and economic backgrounds."

Moffic has discussed the information known about resident training in transcultural psychiatry in 1968, 1977, and 1984. In 1968, less than 30 percent of the programs offered a special course or even part of a course on minority or transcultural issues. By 1977, it had increased to nearly 60 percent but follow-up of these programs in 1984 showed that 40 percent of the programs which had offered a special course on minority or transcultural issues had discounted these courses and 50 percent of those who had previously taught the subject as part of another course had quit teaching it. Reasons cited were loss of funding and loss of faculty, and there consequently seemed to be a regression toward the 1968 level of cultural education (2,3).

Models to teach cultural psychiatry, including a focus on psychiatric care of refugees, can be built into the usual sequence of training by paying attention to the cultural aspects of clinical experiences with the help of culturally sensitive supervision and by supplement clinical exposure through a graduate seminar series. A standard model is described by Wong and others (1). The first post graduate year (PGY-1) includes an introductory cross-cultural seminar on all minorities in the United States, with the objective of acquiring historical knowledge, sensitivity, counteraction of stereotypes, and ability to elicit pertinent interview data with minority patients. In the second year, a cross-cultural seminar studies ethnic groups in greater detail, including completion of psychiatric histories on patients and perhaps home visits to families. Trainees are offered more detailed knowledge of the culture-specific syndromes, concepts of

mental illness, cultural healing systems, and epidemiology of illness. In the PGY-3, the objectives from PGY-2 are expanded and greater depth of knowledge about the various cultures is gained. In the PGY-4, broader issues are extrapolated as principles from specific groups, larger forensic and legislative issues affecting minority groups are reviewed, and adjustment and acculturation problems in different generations of refugees are discussed. Skills to be acquired in this year include effective program consultation on mental health issues affecting minorities.

A second model developed by Moffic (3) differs from Wong's model by deferring focus on specific cultural groups during the first two years of residency, focusing instead on the cultural identity of the residents themselves, their own cultures of origin, and the historical roots of their cultural identities in order to stimulate interest in, and appreciation for, the complex cultural variable in everyone's psychology. The seminar in the PGY-3 focuses on theoretical material and practical issues in patient care with each resident presenting patient issues relevant to a cultural group of his/her own choosing, illustrating a model for learning about other cultural groups and serving as an opportunity for introducing refugee mental health. In the fourth year, electives related to cross-cultural psychiatry and the specific issues in the assessment and treatment of refugees are offered. These seminar approaches, of course, are meant to supplement clinical rotations of several months duration in which residents can treat refugees in a variety of public sector settings such as mental health centers, general hospitals serving as teaching institutions for major medical schools, and primary health care settings.

Didactic courses can also be offered to residents. Foulks (7) details the initial framework for a basic science course in cultural psychiatry for residents, with more theoretical than clinical application. He suggests topics which include medical anthropology, theoretical approaches to understanding disease and illness, psychiatric symptoms in relationship to social integration, change, modernization, and poverty, as well as alternative healing systems, coping mechanisms, and cross-cultural issues in assessment and treatment. Examples of existing courses include a course in social, community, and cultural psychiatry by Drs. Canive and Koss, Department of Psychiatry, University of New Mexico, Albuquerque, which examines themes of psychiatry as a social control agent, family pathology and mental illness, social aspects of intitutionalization, psychiatric epidemiology, and culture's relationship to psychopathology. The focus is on Indians of the Southwest and Hispanics as ethnic examples. Finally, the course discusses community mental health and care of the chronically mentally ill. Another course is a cross-cultural psychology course, also offered for psychiatry residents. The course is delineated in Appendix I and is offered by Drs. Butcher, Tapp, Westermeyer, and Ms. Clark.

Post-Residency Education: Fellowship Training

The psychiatry resident usually begins a fellowship in the fourth or fifth year of residency. The greatest flexibility for choice of clinical electives in the residency years necessary for board eligibility occurs during PGY-4 and, during this year, specialization

is possible in areas such as forensics, consultation-liaison psychiatry, child psychiatry, or administrative psychiatry. Fellowships are also available in geriatric psychiatry or cross-cultural psychiatry, but there is no subspecialty certification for these specializations and, consequently, there are no recommendations for content or structure by any accrediting bodies. Since usually only four years of residency are required to take the adult psychiatry board examinations, a resident who has made an early decision about subspecialization can save time by starting an advanced fellowship in PGY-4. A fellowship in cross-cultural psychiatry usually requires one or two years to complete.

During fellowship training, concurrent enrollment in an advanced graduate degree program, such as an M.A. level anthropology or other social science discipline, is possible. Combining this didactic coursework with clinical experience in a cross-cultural setting can effectively provide an academic concentration in cultural psychiatry with a focus on refugees or a particular refugee cultural group. At the University of Minnesota, the anthropology department piloted a "special" M.A. program in anthropology for professionals trained primarily in other academic areas. Psychiatrists were among the first enrollees, combining this program with relevant clinical experiences. Fellowships in cross-cultural psychiatry have also been offered more formally at the Universities of Hawaii and Connecticut. In addition, "tracks" in community psychiatry, such as that offered to psychiatry residents at the Oregon Health Sciences University, provide opportunities to work clinically with minority groups such as refugees. Fellowships generally include the content areas described in the

preceding section for psychiatry residents, but offer the opportunity to select clinical research projects, become involved with community organization activities, and further develop clinical skills. In the absence of a concurrent formal degree program, clinical conferences, supervision, and seminars would provide the didactic structure primarily.

Post-Residency Education: Continuing Education

Continuing education for physicians is required by all state medical licensing boards for medical license renewal. The requirements vary from state to state, but between 25 and 50 credit hours are required annually. Professional organizations also have requirements for continued membership. The American Psychiatric Association (APA), the dominant organization for psychiatry, requires that members participate in at least 150 hours of continuing medical education (CME) activities in a three-year period. One hour of credit may be claimed for each hour of participation. Sixty hours of credit must be in "Category I", which requires accredited sponsorship. The Physician's Recognition Award (PRA) of the American Medical Association and certificates of relicensure for states having CME requirements comparable to those of the APA are acceptable demonstration to the APA that the requirements necessary for continued membership in the organization have been met. The APA will issue a CME certificate valid for the same time period or will issue a three-year certificate upon receipt of a complete report of 150 hours of CME activities. In the absence of a PRA or relicensure certificate, APA members need only sign

and return a compliance statement to the APA to the effect that the requirement has been met.

Six categories of CME activities apply to the requirement for the APA. Category I activities are sponsored or cosponsored by organizations accredited for CME, meeting standards of needs assessment, planning, professional particpation and leadership, as well as evaluation. Format includes courses, symposia, paper presentations, lectures, workshops, and colloquia. Category I credit is also given for formal training programs (50 hours annually) and for successful completion of psychiatry board or subspecialty board examinations. The remaining categories include formal learning activities, reading and other self-study, publications and presentation of papers. Category II is for activities without accredited sponsorship. Category III is medical teaching of medical or allied health students or professionals, as well as providing organized consultation. Category IV includes papers, publications, books, presentations, and exhibits. Category V is self-instruction or study, self-assessment, consultation, and peer review. Category VI is "other meritorious learning experiences". Of the 150 credits required each three years, all 150 may be Category I but not fewer than 60.

Refugee-related topics, presumably as part of a cross-cultural CME presentation, could most effectively reach psychiatrists and primary care physicians if approved for Category I credit. Self-instruction or study materials related to refugees could also be developed to fulfill requirements for Category V or, if the appropriate requirements are met, for Category I. Development of reading materials or videotapes discussing refugee issues could qualify for CME credit if appropriately

packaged. Perhaps the widest audience of psychiatrists could be reached by working with the APA to develop materials and distribute them under the organizations's auspices. Content areas would best focus on diagnostic and treatment issues. Grand rounds, study groups, journal clubs, and inservice training may also be appropriate formats for presentation of refugee issues.

Development of training centers, as advocated by Wong (1), may provide the critical mass of staff and trainees necessary to focus on a particular cultural group or groups. Workshops for practitioners, as well as fellowship and residency training, could be conducted more effectively in such centers. Although Wong was advocating for an Asian and Pacific American mental health training center, multidisciplinary, regional, and associated with a psychiatry residency, the closest model for refugees is Boston University's Refugee and Immigrant Training Center, based in a school of social work. They offer one or two day-long workshops for medical personnel and others, including information about refugee cultures, services provided, agency changes necessary to improve services, and special refugee needs. An alternative to training centers is to have "experts" in refugee mental health visit different training centers for workshops.

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PSYCHOLOGY

Psychology Curricula

Training in psychology occurs at two levels, the pre-professional level leading to Bachelor and Master of Arts degrees in psychology, and the professional level leading to Philosophy Doctorate or Psychology Doctorate degrees (Ph.D. and Psy.D., respectively).

The B.A. degree is usually the entry point for those students interested in pursuing graduate work in psychology. Students who complete this degree may also take entry level positions in mental health and human services agencies where they function under the supervision of professionally trained staff. The course requirements for the B.A. degree are typically designed to provide a general foundation of knowledge about psychology. Topics pertinent to refugee mental health could be introduced within the context of courses in social, abnormal, personality, and cross-cultural psychology. More specific knowledge about refugees could be imparted through reading lists, course paper requirements and special independent study projects (e.g. undergraduate honors thesis project).

Programs offering training at the master's level can vary considerably. As a general rule, these programs prepare students to function at a more specialized technical level; however, this level of training does not always lead to full professional licensure and/or allow for independent practice within the different specialties of professional psychology (clinical, counseling and school psychology). Training usually involves two years of advanced coursework in

psychology which may cover topics such as statistics and research methodology as well as subjects specifically related to the specialty in question. Supervised practicum experiences may also be part of the curriculum. Additional coursework and special paper(s) are sometimes substituted for a research oriented thesis. Relevant refugee mental health content could be introduced in these programs through seminars, modules within courses, directed readings, special degree papers, and thesis projects. Supervised practice experiences, when required, could be completed in mental health agencies serving refugees.

Mental health and human service agency workers with B.A. and M.A. level training in psychology frequently use supervisory relationships and in-service training programs to upgrade skills and obtain new knowledge. An in-service training component is often required by agency regulations and can be more standardized than supervisory arrangements. Thus, in-service training programs may be particularly useful for introducing refugee mental health content to agency personnel at this level of training.

Professional training in psychology takes place at the doctoral level in three specialty areas: clinical, counseling, and school psychology. Training programs follow two basic models, the more traditional scientist-practitioner model leading to the Ph.D., and the newer practitioner model which embodies a basic service orientation and leads either to the Ph.D. or the Psy.D. Accreditation requirements set forth by the American Psychological Association mandate all training programs to demonstrate commitment to the intellectual and scientific enterprise in psychology. Thus, Ph.D. programs require independent scholarly work representing a contribution to knowledge in the field.

Similarly, Psy.D. programs fulfill this commitment by requiring a primary research project demonstrating an in-depth understanding of some psychological problem or some aspect of psychological theory or practice.

While individual doctoral training programs vary in their focus, accreditation requirements mandate a minimum of three academic years of full-time resident graduate study. Students are required to demonsrate competence in each of four substantive content areas: 1) biological bases of behavior (e.g. physiological psychology, comparative psychology, neuropsychology, sensation, psychopharmacology; 2) cognitive-affective bases of behavior (e.g. learning, memory, perception, cognition, thinking, motivation, emotion); 3) social bases of behavior (e.g. social psychology, cultural, ethnic, and group processes; sex roles; organizational and systems theory); and 4) individual behavior (e.g. personality theory, human development, individual differences, abnormal psychology). In addition to academic training, doctoral programs in clinical, counseling and school psychology include systematic intensive field training which is usually offered sequentially through practica and internship experiences. Again, the specific structure of practica and internship experiences varies according to the psychological specialty and also, to some extent, within each specialty. However, both practicum and internship training are governed by specific APA standards and guidelines. The minimum practicum experience is 400 hours, of which at least 150 hours is to be spent in direct service experience and at least 75 hours in formally scheduled supervision. Internships in clinical psychology require a full-time experience to last one calendar year. School and

counseling psychology internships require a full-time experience for either the academic or calendar year.

Refugee Mental Health Content in Psychology Curricula

It is important to note that APA accreditation requirements state that "all psychology departments and schools should assure that their students receive preparation to function in a multi-cultural, multi-racial society" and that training programs ". . . develop knowledge and skills in their students relevant to human diversity such as people with handicapping conditions, of different ages, genders, ethnic and racial backgrounds, religions, and lifestyles; and from different social and individual backgrounds." (Criteria for Accreditation of Doctoral Training Programs and Internships in Professional Psychology, American Psychological Association Council of Representatives, January 1979, amended January 1980.) Thus, with respect to professional psychology training, there are not only opportunities but also a mandate to introduce content that would apply specifically to refugee mental health concerns.

Content specific to refugee mental health could be introduced at the coursework level, through the typical research requirements, and at the practicum and internship level. At the coursework level, for example, the following topics might be included; techniques and issues in cross-cultural psychological assessment, principles of psychological test translation and adaptation, crisis intervention and psychotherapy with refugees, psychoeducational assessment of refugee children, etc. CROSS-CULTURAL PSYCHOLOGY, by James Butcher and others, is an example

of a graduate level course in cross-cultural psychology that covers topics relevant to refugee mental health. (See Attachment I for a description of the course.)

Formal post-doctoral training in the professional psychology specialties usually takes place through highly individualized arrangements which depend on the specific interests of trainees and the needs and resources of institutions. However, one APA-approved training program, The Psychodiagnostic Training Clinic of the Center for Multi-Cultural Training in Psychology, Boston City Hospital, offers specialized multi-cultural training in clinical psychology at both the pre-doctoral (internship) and post-doctoral (fellowship) levels. (See Attachment J for a description of the PTC training program.)

Continuing Education in Psychology: Refugee Content

Further training in psychology at the post-doctoral level is usually obtained through attendance at professional conferences, workshops and seminars which are typically offered by professional organizations or through university-based continuing education programs. The APA has developed specific regulations for approval of continuing education programs offering credits to psychologists. Continuing education programs in psychology tend to be very responsive to the training needs of their participants since they depend on registrants' fees for support. Thus, these programs represent a useful and effective established avenue for psychologists to obtain increased knowledge about the various aspects of refugee mental health needs. Topics of interest to practitioners at this level of expertise are

likely to be very similar but perhaps somewhat more specific than the ones listed above. They may include the following: conducting psychological testing and psychotherapy through interpreters, interpreting psychodiagnostic test data from refugee patients, crisis intervention with refugee clients, supervision of bilingual mental health staff, models of mental health care for refugees, and prevention strategies for refugees.

NURSING

Educational Preparation for Nursing

Pre-service professional education in nursing includes the baccalaureate, masters and doctoral programs. There also are the two and three-year associate degree and diploma programs and the practical nurse and home health aid programs. Nursing curricula vary considerably but, in general, they are approved by state boards of nursing and accredited by the National League of Nursing. Nurses must pass state competency examinations in order to be licensed to practice as Registered Nurses or Licensed Practical Nurses. In states where there are mandatory continuing education requirements in place, license renewal may require continuing education in programs approved by state boards.

Baccalaureate Programs

Most nursing students receive their nursing education in colleges and universities. A typical baccalaureate nursing program leading to the bachelor of science degree in nursing is four years in length and requires a basic science, arts and humanities background to support the six or eight quarters of the upper division nursing major. Prerequisite courses generally include psychology, sociology, cultural anthropology, and communication along with certain physical and biological sciences and English. Nursing curricula emphasize the individualization of patient care and behavioral sciences as a prominent part of the nurse's training. The nursing perspective regards persons holistically and includes a consideration of the variables that contribute to the wholeness of persons and affect their health status: biologic, behavioral, spiritual, cultural, family and lifestyle. Nursing education emphasizes helping relationships, communication, and human responses as individuals are exposed to stress and change. These concepts are explored and applied in a variety of clinical settings. Specific courses which may focus on mental health include psychosocial nursing, psychiatric/mental health nursing, and community health nursing. The study of specific minorities or transcultural issues is most commonly an elective option. The National League for Nursing, the accrediting body, requires the inclusion of psychiatric nursing and cultural components in baccalaureate nursing programs.

All nursing education includes clinical experience in conjunction with the didactic coursework. Efforts are made to provide clinical

experiences as varied as possible and, depending on the clientele served by the field agency, cross-cultural experiences are often provided. Community or public health field experience is a setting for nursing practice often incorporated into the curricula of departments of nursing.

Masters Preparation

A Master of Science in Nursing degree typically requires five to six quarters of full-time post-baccalaureate study. Some twenty credit hours must be in a nursing specialty, psychiatric/mental health being one. For example, at the University of Minnesota program, as in many masters degree programs in nursing, community mental health nursing and family therapy would be included in a psychiatric/mental health clinical nurse specialist course. Preparation of practitioners for primary health care is appropriate at the masters degree level. The Standards of Psychiatric and Mental Health Nursing Practice of the American Nurses' Association (1982) have to be met to qualify for certification as a clinical nurse specialist in psychiatric/mental health or primary health care nursing and for membership in the respective professional councils in the professional organization, the American Nurses' Association.

Doctoral Preparation

Doctoral preparation in nursing is more often a research rather than a practice program. Students come to doctoral programs with

masters degree preparation for professional practice. Doctoral coursework and clinical nursing research take place in nursing departments with collaborative work in such departments as anthropology or public health.

Practical Nurses and Nursing Assistants

The practical/vocational nurse is prepared to function in two roles: to give direct nursing care to patients in relatively non-complex situations under the supervision of an RN or physician and to assist the RN or physician in more complex situations. The 12 to 18-month training programs are often organized around learning modules to allow for individualization of learning under the supervision of a professional nurse.

Vocational-technical institutes offer nursing assistant training programs which prepare nursing assistants to work with the sick and injured under the supervision of a professional nurse. The training program typically is of 200 hours and includes classroom coursework and clinical experience in a health care facility.

Refugees have used these practical nurse and nursing assistant training programs as a way to enter health care work and some refugees have gone on to full professional training as their skills, confidence and English have improved.

Cross-Cultural Content in Nursing Curricula

Despite the nursing perspective that views individuals holistically and education that emphasizes biologic, behavioral, spiritual, cultural and family and lifestyle factors that affect health status, nursing curricula have not generally incorporated content on the cultural context of nursing practice. In 1955, Leininger declared that nursing could no longer ignore the multicultural context of practice and, in 1966, developed the concept of "transcultural nursing" whose major focus was the development of a scientific and humanistic body of knowledge in order to provide culture-specific and culture-universal nursing care practice to "help nurses incorporate cultural concepts, theories and research findings into nursing care practice and into nursing education." (Leininger, 1978).

In 1984, however, it was reported that only 18 percent of the baccalaureate schools of nursing included "some cultural and/or transcultural nursing concepts" and only 13 percent of the masters level programs included "some cultural concepts" (Leininger, 1984). A study by the Howard University School of Social Work found that although nurses are one of the largest groups of mental health workers, they have not been adequately prepared to deliver quality psychiatric and mental health services to Afro-Americans, have a limited understanding of cultural pluralism with respect to Asian Americans, and are not being prepared in nursing schools to deal with the mental health problems of American Indians, Alaskan natives, and Hispanics (Chunn, Dunston and Ross-Sheriff, 1983). On the other hand, the orientation of nursing education and the nursing perspective do allow

and encourage the inclusion of cross-cultural content such as refugee mental health.

The American Nurses' Association Code for Nurses, 1976, specifies that consideration for individual value systems and lifestyles be included in the planning and delivery of health care for each client. In 1977, the National League of Nursing mandated the inclusion of content regarding cultural diversity for accredited baccalaureate nursing programs. As a result of these combined factors, investigation of cultural diversity has become an important area for nursing research (Tripp-Reimer, 1984).

In nursing programs where they are offered, transcultural nursing courses may provide content on family and kinship in a social and behavioral context or culture and ethnic variations with specific attention to urban settings. The University of Washington School of Nursing, for example, offers a program of advanced community health nursing that includes content on nursing from a biocultural perspective and a course on transcultural nursing practice. (See Attachment K.) A similar Master of Science in Nursing specialization in cross-cultural nursing is offered by San Diego State University School of Nursing. (See Attachment L.) In two and three-year programs, content on cultural awareness is usually included in the general overview courses; refugee concerns might be incorporated into case conferences or as part of the clinical experience.

Nurses are particularly receptive to continuing education, especially in states that require continuing education as part of relicensing by state boards of nursing. The guidelines of the National League for Nursing, 1977, and the American Nurses' Association's 1982

Standards of Psychiatric and Mental Health Nursing Practice generally apply to psychiatric nursing.

The most explicit position satement on cross-cultural content in nursing education appears in the 1986 statement of the American Nurses' Association Council on Cultural Diversity in Nursing Practice, CULTURAL DIVERSITY IN THE NURSING CURRICULUM: A GUIDE FOR IMPLEMENTATION. The objectives of a culturally-diverse curriculum in schools of nursing are stated to be:

1. To prepare students to give safe, effective care to clients from diverse backgrounds based on knowledge of the client's ethnic and socio-cultural perspective.

2. To provide students with an opportunity to develop understanding of their own culture and of the degree to which they are conditioned by it.

3. To assist students to develop an appreciation and acceptance of individuals with different values, life-styles, and religious and ethnic backgrounds.

4. To help students gain the ability to seek information about the family roles, beliefs, and practices of their clients; the meaning of health and illness to the family unit; and cultural healing practices and beliefs.

5. To foster the integration of cognitive and affective learning with experiential learning so that students develop an understanding of cultural differences.

6. To assist students to develop sensitivity and respect in caring for culturally diverse patients who do not conform in values, beliefs, and mores to the majority group.

Although the statement does not refer to specific ethnic or racial groups nor to particular nurses' training programs, clearly it could encompass content on refugees in general and on refugee mental health in particular. The Statement is available from the American Nurses' Association, 2420 Pershing Road, Kansas, City, MO 64108.

Four major approaches to incorporating content on cultural diversity into nursing curricula are enumerated: the concept approach, the unit approach, the course approach, and the multidisciplinary approach. In each approach, key content components include values clarification, cultural awareness, and human relations. Course content would include the origins of the various ethnic and minority groups (giving students a historical perspective); cultural belief systems, values, customs, and habits; the concepts of culture, acculturation and assimilation, culture change, biculturalism, culture shock, and cultural relativism; and the differences between the perceptions held by those within a culture and the perceptions held by those outside a culture. Various foci of content on cultural diversity are the individual, the family and group, organizations and institutions (such as clinics, hospitals, religions, government and educational systems) and society.

Refugee Mental Health Content in Nursing Curricula

The four major approaches of the ANA policy statement on cultural diversity in nursing curricula constitute, in effect, four different models of cross-cultural training in nursing education that could be

adapted to incorporate refugee mental health content into nursing curricula.

Since preparation for practice as a clinical nurse specialist takes place at the graduate level, certification for practice (governed by the ANA) would be involved. Seminar content could address such concepts as cultural diversity in therapy, cultural variables in mental health nursing, cultural incongruence as a barrier to therapeutic relationships, and patterns of communication. A practicum with refugee families could add to content refugee phenomena (such as torture and trauma), family nursing cross-culturally (abuse, violence), group therapy, working with traditional healers and working with interpreters.

Refugee-specific mental health seminars and courses could be available, with or without a practicum, at both undergraduate and graduate levels. Inter-disciplinary seminars could deal with more specific concepts and problems, such as grief and child abuse. At the doctoral and postdoctoral levels, research and dissertation topics might include various aspects of refugee mental health as they bear on nursing practice.

Much refugee mental health content is appropriate for incorporation into continuing education curricula; that is, in the form of workshops, conferences, in-service training, study-tour experiences, and continuing education classes. Programs that prepare practical/vocational nurses and nursing assistants have attracted students of minority and refugee backgrounds. These programs are both terminal degree programs and stepping stones to further training. Some programs are designed specifically to prepare nurses with foreign

degrees for state licensing. An example of such a program is one conducted by the School of Nursing of the University of Texas in Houston for Vietnamese nurses. (See Attachment M.)

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ALLIED HEALTH PROFESSIONS

The allied health professions include several medicine and health-related groups--for example, occupational therapists, physical therapists and therapeutic recreation specialists. Their functions are primarily rehabilitative and restorative in connection with some disabling physical or mental condition. Their significance for refugees and refugee mental health is that allied health professionals practice in a wide range of health, mental health, and social service settings with which refugees come into contact: rehabilitation centers, residential treatment centers, hospitals, clinics, developmental learning centers, long-term care facilities, day care and treatment centers, group homes, vocational rehabilitation agencies, community education agencies, and community centers. The focus of their practice is also on "special populations", that is, of persons with problems of illness, physical disability, mental retardation, developmental disabilities, multiple handicaps, mental illness, chemical dependency, crime and delinquency, aging, and physical and sexual abuse.

The training programs are governed by the accreditation standards of their national associations which generally prescribe that the programs be offered in a college or university, include both a pre-professional social science base and a professional program, and incorporate field work or an internship as an integral part of the curriculum. The American Occupational Therapy Association recommends that OT students work at least three months in a mental health setting. Both baccalaureate and masters degree programs are offered. Associate

degree programs and therapist assistant programs are offered by some colleges, for example, by community colleges.

Allied Health Professional Training and Refugee Mental Health

Although the allied health professions are concerned with persons with disabling physical and mental problems, the training programs do not generally incorporate cross-cultural content although, presumably, many of their patients or clients have problems that are culture-related or the therapy must take into account the cultural differences between therapist and patient or client. Nor do accreditation standards require or expect cross-cultural content in the curricula.

The integration of cross-cultural or refugee mental health content into allied health professional training could take place at several places in the curriculum:

1. In the social science preprofessional part of the training program, cross-cultural content could be introduced through courses in such disciplines as anthropology or sociology or special area studies such as in Black, American Indian, Asian, and Hispanic departments. Human development courses can incorporate cultural factors into the developmental process. Social science departments also provide opportunities for various forms of field experiences and observations in agencies that serve culturally different groups where research and projects are possible.

2. In the professional portion of the training program for the allied health professions, opportunities for incorporating cross-cultural content are present in both the class and clinical component.

A cross-cultural course in anthropology or human development could introduce students to the diversity of cultures, the different attitudes to health, illness and service delivery systems, and the implications of cultural differences to the therapist-client relationship. Refugee case examples could be used in any of the professional courses to broaden students' awareness of cultural factors in treatment and diagnosis. Perhaps the most significant way of involving students in refugee mental health would be through their clinical assignments. Suitable placements in refugee-serving agencies are available in many hospitals, centers, and clinics that are located in areas in which refugees reside.

Graduate students often pursue their studies in a joint degree program or in cross-disciplinary studies as in public health, public administration, or social work. Cross-cultural and refugee content are often available through these joint programs.

For employed allied health professionals, continuing education would seem to be a particularly effective way of enhancing their awareness of refugees and refugee mental health as well as the broader aspects of cross-cultural practice. Continuing education can take the usual forms: courses and workshops offered through continuing education departments of the professional schools and programs, symposia, and workshops offered at various conferences sponsored by their national associations or related associations. The content of this continuing education can range from background information about the refugee phenomenon to specific culturally-sensitive practice methods in work with refugees.

HUMAN SERVICE GENERALIST PROGRAMS

General Characteristics

There are a wide variety of undergraduate programs, variously called "human service generalist" programs or "human relationships" programs, in two-year and four-year colleges. It is difficult to generalize about them except to say that most are social work-based programs, their faculties tend to include at least a core of social work instructions and many, in fact, are pre-social work programs. They provide training for the large numbers of staff who are employed in paraprofessional positions in what is loosely termed the "human services" including: public assistance, corrections, nursing homes, mental health, social services and some areas of health. Some training is broad brush and generic; other programs are more narrowly focused, for example, on alcoholism counseling or in areas such as aging. Usually there are opportunities for a degree of specialization, as in aging, law enforcement, and family studies. All involve some kind of internship, usually in association with some area of specialization.

The significance of the human service generalist programs for refugee mental health is two-fold: first, the number of these programs has expanded rapidly with the increase in the number of two-year community colleges and the increase in the demand for paraprofessional staff in the many human service agencies, including mental health agencies; and, second, the programs offer entry-level higher education training opportunities for refugee bilingual paraprofessionals who aspire to mental health careers. They are a means of upgrading the

competence of currently employed refugee bilingual staff, establishing a career line for refugee paraprofessionals who will have acquired a recognized academic credential, and creating a pool of potential bilingual, bicultural recruits to full professional training. See Attachment N for a description of the George Washington College Social Service/Mental Health program.

With respect to mental health, typically the human service generalist programs offer course work in social policy and community services and in mental health principles and practice. Since much of "human services" practice involves individuals from lower socioeconomic groups and racial minorities (for example in counseling, referral, and crisis intervention based on a developmental framework in work with families, children and youth, and the aging), the inclusion of cultural factors is natural. The internship in a human service agency invariably will bring students into contact with individuals and groups of different races and cultures. Thus, the incorporation of cross-cultural and refugee content into the curricula could take lines similar to those applicable to the social work curriculum: a specialization, a course on refugees and refugee mental health, various "modules" that incorporate refugee content, and a field placement in a refugee-serving agency.

The Hahnemann University Associate in Mental Health Program

A particularly interesting example of a two-year mental health associate degree program for bilingual refugees is that of Hahnemann University, School of Allied Health Professions, Philadelphia. The

program aims to produce technically well-trained paraprofessional mental health staff who can complement mental health professionals in prevention, outreach, diagnosis, and treatment of high-risk, culturally different, inner city populations. The focus of the training is on practical skills and includes coursework, seminars, practica, and supervised field experiences. Although the University is responsible for assessment of English language ability and general academic potential, the area refugee mutual assistance associations have done most of the recruiting for the program. Students are sent to an affiliated college for six weeks of intensive English language training. Thus, the Hahnemann two-year program represents an interesting example of collaboration between a university and the refugee community toward the goal of preparing bilingual, bicultural personnel who, at the completion of their training, will have a recognized academic degree from a well-known university. Moreover, the students can complete an additional two years of classroom and clinical training and obtain the B.S. degree. (A summary report on the Hahnemann associate of mental health program is contained in Attachment O.)

Adelphi-Institute for Child Mental Health Training Program for Emigres

Another example of a human services training program specifically for immigrant and refugee personnel is that operated by the Institute for Child Mental Health, New York City, affiliated with Adelphi University. This is an on-the-job, 35-hour per week, 20-week training program of class and supervised field instruction designed to equip

students for entry level human services employment. Between 1978 and 1986, trainees have included 321 refugees from Cuba, Haiti, Vietnam, Cambodia, Laos, Ethiopia, Afghanistan, Zaire, Poland, Rumania and the Soviet Union. Trainees are provided on-going counseling by experienced professional social workers in individual and group sessions and training content reflects the multi-cultural nature of the refugee population to equip students to practice within the American pluralistic society. Graduates receive a Certificate of Completion as well as 10 undergraduate credits from the Adelphi University School of Social Work. (See Attachment P for a description of the program.)

PRIMARY HEALTH CARE PROVIDERS

Primary Health Care Providers and Refugee Mental Health

Although this report has been concerned primarily with training for the core mental health professions, mention should be made of the crucial role of primary health care providers in refugee mental health. The primary health care system usually is the first contact that refugees make in search of health care. Primary health providers--family practice physicians, internists, pediatricians, obstetricians/gynecologists, nurse practitioners, and community health nurses--serve as the first point of contact with refugees in the health care system by screening, diagnosing, and treating the physical and mental health problems of refugees. Refugee perception of mental health problems and treatment often is one of institutionalization. Refugee mental health problems often are expressed as somatic

complaints. Like many other patients, refugees may go for treatment of somatic complaints to a primary health service. This means that the primary health staff must be trained in cross-cultural diagnosis and treatment and be able to detect mental health problems.

An example is the Community-University Health Care Center, a clinic of the University of Minnesota Hospital and Clinic that is designated and funded by the Community Mental Health Program to provide mental health care to refugees. It is a typical community primary care clinic in the services it provides. However, it is different in that it serves large numbers of refugees, mostly Southeast Asians, which is unlike most community primary health care clinics. It is a neighborhood-based center that serves a low-income city-wide population and provides family-centered, comprehensive, primary health care by an interdisciplinary staff. Mental health and social services are an integral part of the primary health care services. The Center also provides field instruction, clerkships, and practica for students in the University's professional schools and social and behavioral science departments. (See Attachment A for a description of CUHCC and its training program for staff who serve refugees.)

Incorporating Refugee Mental Health Content into Physician Training

Two models for introducing refugee mental health content into the pre-service training of physicians suggest themselves. The first model would attempt to introduce into the medical school curriculum some information about refugees for all medical students irrespective of their intended subspecialty. In theory, this would be ideal because a

large percent of medical school graduates go into Family Practice; all students would have a base of information that could be used in whatever subspecialty is pursued and to whatever community in which he or she settles. The course could cover such content as the refugee phenomenon, refugee demographics, the refugee experience, the impact of acculturation, and the kinds of conditions commonly encountered from the medical and mental health perspectives. This content would be didactically presented. The difficulty with this approach is that it is extremely difficult to corner even one extra hour in the medical student curriculum; the displacement of other content would be necessary.

An alternative model would be to introduce refugee mental health content at the resident level. Unfortunately, at this level, the opportunity is lost to have a consistent presentation across the programs because each residency program decides for itself what it considers necessary for the resident's training. In addition, the content would be presented to different groups of students; it would be impossible to schedule a lecture or course on refugee mental health for all residents at any given time because the residents often are scattered across a number of hospitals or clinics over the usual three years of the pediatrics or family practice residency.

The refugee mental health content presented to residents could be similar to that presented to medical students although it could be made subspecialty-specific. For example, in Pediatrics, commonly encountered pediatric problems encountered with refugees could be emphasized with less emphasis on mental health or adult health. Since Family Practice cuts across all of the subspecialties, instruction in

refugee health would include the gamut of refugee health. An example of a course on cross-cultural medicine, specifically on the Hmong, is that offered in the Department of Family Practice, University of Minnesota Medical School (See Attachment Q).

Continuing Education of Primary Health Care Providers

A continuing education model of refugee mental health would consist of training directed to employed primary health care providers so that they could reach and treat both the biomedical and psychosocial dimensions of refugee health. This model is illustrated in the concept paper by Mollica and Thompson (See Attachment R). The concept is to "integrate refugee mental health care in the primary care that refugees are already receiving in existing mainstream institutions". Moreover, the proposed training program would be integrated into the mainstream educational system through an affiliation with a university continuing education department.

INTERPRETING IN REFUGEE MENTAL HEALTH

A special aspect of refugee mental health has to do with the language and cultural barriers between refugees and professional mental health providers who do not speak the refugee language. This is a universal problem of all patients and clients who do not speak the customary language, including the deaf. The usual practice, if a mental health agency wishes to serve refugees, is to employ bilingual refugee paraprofessionals, train them to at least quasi-

paraprofessional status, and employ them in outreach and treatment under professional supervision. Although sometimes called interpreters or translators, these bilingual refugee paraprofessionals do not consider themselves interpreters and usually are called variously clinician, mental health worker or bilingual paraprofessional although they often act as interpreters for professionals who do not speak the refugee language. Professional training of personnel who work cross-culturally with refugees should include training on how to relate to and supervise bilingual refugee paraprofessionals.

In addition, there is a need for skilled professionals who are, in fact, trained interpreters competent to interpret in mental health. Training involves training both for the interpreters and for mental health professionals in how to use the professional interpreter. This aspect of professional training in refugee mental health is discussed in the concept paper, LANGUAGE PLANNING FOR INTERPRETING AND TRANSLATING SERVICES: A FUNDAMENTAL CONTENT AREA FOR INCLUSION IN MODELS OF PROFESSIONAL AND PARAPROFESSIONAL TRAINING IN REFUGEE MENTAL HEALTH, by Laurel Benhamida, Attachment S.

CREDENTIALING OF REFUGEE MENTAL HEALTH PERSONNEL

A problem of special concern is that of "credentialing" refugee mental health personnel, both professional and paraprofessional. Most refugees with professional degrees from foreign universities or schools cannot meet state licensing requirements to practice and most refugee paraprofessionals employed by mental health agencies lack the academic credentials for mental health work. Thus, the training problem is

twofold: 1) to prepare refugee professionals who have foreign degrees, as in medicine and nursing, to meet state licensure requirements for their professions and 2) to equip refugee paraprofessionals with academic credentials so that they can meet the minimum or desired qualifications specified in civil service or private agency position descriptions.

All states regulate medical practice and nursing and many regulate psychologists and social workers. With respect to refugees who have foreign medical degrees, the problem is almost insurmountable, in large part because of the difficulty of gaining admission to residencies. Some success has been achieved with refugee nurses through special programs and projects to prepare refugee nurses for licensure, for example, the project of the University of Texas School of Nursing at Houston, a nine-month program that was offered in 1985 and 1986 and from which twenty-nine Vietnamese nurses graduated. (See Attachment M.)

A promising route to credentialing and subsequent career ladders in mental health is through preprofessional training as in nursing, the allied health professions and the human service generalist programs already described in this report. Such training upgrades the competence of currently employed refugee staff, provides the refugee bilingual workers with an accepted academic degree that can lead to a career ladder, and creates a pool of potential recruits to full professional training. Many of these pre-professional programs are offered through community colleges and vocational/technical schools as well as state colleges and universities that are more conveniently

located, have lower tuition than typical residential professional programs, and are amenable to part-time study.

The American Refugee Committee, for example, has been actively engaged in recruiting and assisting refugees, including professionals with foreign degrees, to return to formal educational programs and to arrange collaborative programs with degree-granting institutions so that refugees can receive college credit for courses taken. (See Attachment N for a description of the Social Service/Mental Health program of Harold Washington College, a City College of Chicago, with which the American Refugee Committee has a collaborative working relationship.) ARC enrolls refugee student candidates in the social services program which includes the first two years of liberal arts that will be transferable to four-year colleges and universities.

One of the long-range goals of refugee mental health training surely must be the training of refugee bilingual mental health providers in formal pre-professional and professional training programs, especially if the goal of refugee mental health is to "mainstream" refugee mental health and refugee bilingual personnel into mainstream mental health systems. Without credentials, the jobs of bilingual refugee paraprofessionals are essentially dead-end jobs with little prospects for advancement and promotion in a career line. Credentialing is an essential element of any long-range refugee mental health strategy.

ATTACHMENT A: Community University Health Care Center

Community-University Health Care Center
Health Sciences
2016 - 16th Avenue South
Minneapolis, Minnesota 55404
(612) 627-4774

Contact person: Bonnie Brysky, MSW, Mental Health & Social Services Coordinator

Program Title: In-Service Training

Trainees: Social service, mental health and refugee service staff

Community-University Health Care Center is a neighborhood-based family-centered comprehensive health and human service agency. It provides primary health care as well as mental health and social services.

The in-service training program is multi-faceted and directed toward the entire staff as well as specific service units. It is planned both by the administration and supervisory staff as well as by the line staff. There is no staff position that has the assigned major task of planning and carrying out the in-service program. Special funding is at times available to bring in outside experts for a fee. In many instances, outside agency experts provide services without charge.

In general, topics for presentation and discussion are selected as they emerge from the daily clinical practice of the multidisciplinary staff.

Throughout the year, there are two hour, monthly presentations by out-of-agency experts. The programs are planned by two staff members who assume responsibility for the programming for an entire year. Mental health related topics have included child protection, suicide

assessment, psychological testing and anxiety disorders. Films on a wide range of topics including racial differences and the Indian Health Service are shown,

Other sessions planned by administrators and supervisors have targeted racism and homophobia in a two-day conference. A twelve hour continuing series by an outside specialist on productivity in the workplace was planned for the entire staff.

Special programming for the bilingual paraprofessional staff is developed for their special needs. In the past, these have included three sessions, two hours in length, by an outside specialist, on sexual assault; three sessions of two hours in length, by an in-house specialist, on chemical dependency; and two sessions lasting two hours each, by an outside expert and an in-house specialist, on domestic abuse.

The bilingual paraprofessional staff also meet one time per week for one hour for a case discussion that is focused on education. This is led by a mental health professional from the agency and is distinct from the worker-supervisor conferences scheduled routinely for supervision purposes.

The adult team consists of a core group that meets one time per week with a consulting psychiatrist. Specific cases are discussed. Any staff can present a case for discussion and the meeting is open to the entire staff.

The child team similarly meets with a licensed consulting psychologist once a week for case consultation with the conference open to the entire staff.

Three times per year (for two hours), the entire staff meets for a discussion of house policies and regulations. Much of this has to do with "recording and paper work". A follow-up meeting is held after each session for the bilingual staff to insure their understanding of the details and changes in procedure.

Reference:
Reported by Bonnie Brysky, Mental health and social services coordinator

ATTACHMENT B: Wilder Refugee Social Adjustment Program

Refugee Social Adjustment Program
Amherst H. Wilder Foundation
919 LaFond
St. Paul, Minnesota
(612) 222-2876

Contact person: Thomas J. Rogers, Director

Program Title: Mental Health Training for Refugee Service Workers and Community Leaders

Trainees: Hmong non-professional service workers and community leaders ("natural helpers")

This training project which was specifically directed toward the training of Hmong "natural helpers", i.e., community leaders, church/religious leaders, traditional healers, clan leaders, community members, and bilingual service workers, was conducted over ten sessions. The training emphasized mental health, along with social adjustment skills and issues, and information about community resources in order to:

1. Increase the effectiveness of Hmong community support systems in responding to the mental health and social adjustment needs of members.

2. Gain knowledge about the effectiveness of selected methods of training Hmong "natural helpers" and bilingual service workers.

3. Gain a better understanding of Hmong community support systems.

4. Gain a better understanding of how Hmong community support systems can be supported and linked more productively with the "mainstream" mental health and social service systems.

Some sessions were conducted in or translated into Hmong or Lao in order to maximize participation by participants and presenters. The content of the sessions included: an introduction to basic health concepts and Hmong health; the American social service/welfare and education systems; the family; loss and grief; helping people with emotional and social adjustment problems; the workplace; and leadership and advocacy. An evaluation of this training project was completed and a guide for planning and implementation of such a training program is available.

References:

Robinson B: (1985). Final Evaluation Report of the Community-University Health Care Center (CUHCC) and the Amherst H. Wilder Hmong Community Leader and Helper Training Project. Minnesota Refugee Mental Health/Social Adjustment Demonstration Project.

Rogers T: (1984). A guide to Planning and Implementing a Social Adjustment Training Program for Refugee Natural Helpers. (Grant #83-PE-MN-51-151) Washington, D.C.: Office of Refugee Resettlement.

ATTACHMENT C: Fact Sheet

UNIVERSITY OF MINNESOTA

Refugee Assistance Program - Mental Health
Technical Assistance Center
Box 85 Mayo
University of Minnesota Hospitals
Minneapolis, Minnesota 55455

Amos S. Deinard, MD, MPH, Director

(612) 627-4325

The Refugee Mental Health Resource Development and Technical Assistance Center was established under a three-year contract with the National Institute of Mental Health (NIMH Contract No. 278-85-0024 CH) to provide technical assistance and consultation to state mental health agencies and particularly to twelve state Refugee Assistance Programs that were awarded NIMH grants for refugee mental health programs: California, Colorado, Hawaii, Illinois, Massachusetts, Minnesota, New York, Rhode Island, Texas, Virginia, Washington and Wisconsin.

The objectives of this NIMH initiative are:

1. To develop a refugee planning, program development, advocacy, and coordination capacity within each of the funded state mental health agencies.

2. To establish a nationwide refugee mental health resource development and technical assistance capacity.

3. To increase the number of trained refugee mental health professionals to provide clinical services to refugees.

4. To insure more effective placement, utilization and career development of trained refugee paraprofessionals within agencies providing mental health services to refugees.

5. To develop needs assessment and ongoing epidemiologic studies regarding refugee mental health.

Refugees are people who have left their home country and are unable to return because of persecution or a well-founded fear of persecution, as defined in Section 010 (a) (42) of the Immigration and Nationality Act as amended by the Refugee Act of 1980. Refugees include entrants, Cubans and Haitians who arrived in the U.S. between 21 April 1980 and 10 October 1980.

The work of the Center has been divided into a number of tasks:

Project Orientation.--Review all published literature on refugee mental health and make periodic updates. An annotated bibliography of refugee mental health has been produced and distributed to the twelve RAP states.

Needs Assessment.--Provide consultation and technical assistance to the state RAPs on refugee mental health needs assessment, facilitate linkages between states on needs assessment methods and assist states in identifying gaps in the refugee mental health service delivery system. A technical paper, MODELS AND METHODS FOR ASSESSING REFUGEE MENTAL HEALTH NEEDS, has been distributed to the twelve RAP programs.

Mental Health Professionals.--Design a system for identifying refugee and other mental health professionals and paraprofessionals who are available for employment with refugee mental health programs.

Culturally-Sensitive Models for the Prevention, Diagnosis and Treatment of Mental Health Problems.--Identify successful, culturally-sensitive models of refugee mental health diagnosis, treatment, and prevention; assess the adaptability of these models to mental health providers; and identify valid culturally-sensitive instruments for

psychological and/or neuropsychological assessment of refugee populations.

Models of Instruction.--Identify successful, culturally-sensitive training programs that can be used as models for the development of refugee and other mental health professional and paraprofessional mental health workers, including the location of possible placements for field experience in refugee mental health.

Resource Component.--Develop models of prevention, diagnosis, and treatment of refugee mental health problems and models of instruction in order to respond to the gaps in service delivery identified in the needs assessment.

Work Groups.--Facilitate the sharing of knowledge among the states and other interested organizations through national workshops.

Each task has been assigned to one of several teams, each headed by a team leader:

Team A, Project Orientation: Team Leader, Carolyn Williams, PhD, Psychology.

Team B, Needs Assessment: Team Leader, George Hoshino, DSW, Social Work.

Team C, Mental Health Professionals: Team Leader, Amos S. Deinard, MD, Pediatrics.

Team D, Models of Service: Team Leader, Joseph Westermeyer, MD, Psychiatry.

Team E, Instruction: Team Leader, George Hoshino, DSW, Social Work.

Team F, Work Groups: Team Leader, Bruce Downing, PhD, Linguistics.

In the first year of the project, Center staff focused on the literature search, needs assessment, and models of diagnosis, treatment, and prevention of refugee mental health problems. The literature search has been completed and an annotated bibliography on refugee mental health has been distributed. A needs assessment technical paper has been provided by the RAPs along with examples of needs assessment methods and instruments. Models of assessment and service have been developed, a site visit team has examined a number of refugee mental health programs and a report on models of culturally-sensitive refugee mental health programs has been prepared. The second year of the project has focused on the training and resource development components. Two workgroups involving TAC and RAP staff have been held to share knowledge among the states and interested organizations. Additional workgroups will be conducted during the second and third years of the project.

ATTACHMENT D: Introduction to TAC report, CULTURALLY-SENSITIVE REFUGEE MENTAL HEALTH TRAINING PROGRAMS

CULTURALLY-SENSITIVE REFUGEE MENTAL HEALTH TRAINING PROGRAMS

INTRODUCTION

A responsibility of the Technical Assistance Center is to identify culturally-sensitive training programs for professionals and paraprofessionals who provide mental health services to refugees and for others who are directly or indirectly involved in refugee mental health, and to develop models of training for refugee mental health. This report has been prepared in partial fulfillment of that responsibility.

It is a truism that the quality of an agency's program--indeed, whether it will even be accessible to and used by its intended clientele--is very much a function of the kind and quality of its staff. In turn, kind and quality of staff are largely functions of training, whether acquired through formal academic training in an educational institution or through agency-provided training.

For the mental health services in general and for refugee mental health services in particular, the kind of training staff receives is crucial. To work in the field of mental health requires far more than common sense, compassion and good intentions. It requires an understanding of the nature and symptoms of mental illness and the conditions of mental health, a knowledge of the factors that predispose to mental health problems or that alleviate or prevent them, and skill in diagnosing, treating, and preventing mental health problems.

Refugee Mental Health: Language, Cultural, Racial, Experiential, Socio-economic Factors.

For refugees, the task is further complicated by language, cultural and racial barriers between the refugee and his or her community and the mental health agency and its staff. Although cultural factors normally are considered in mental health diagnosis and treatment, refugees bring unique cultural, socioeconomic, and experiential factors to their relationship with the mental health agency and the mental health practitioner.

It has been well established through clinical observation and surveys that although refugees have displayed remarkable tenacity and resilience through the travails of their migrations they also exhibit a very high incidence of mental health problems, many severe. These problems often manifest themselves only later in the resettlement process, after such immediate needs as housing and income are managed. Moreover, mental health problems affect the family as a whole and its individual members, for example, children and youth of refugee families.

To be "culturally-sensitive", refugee mental health training must take into account the differences between refugees and other immigrants and other resident racial and ethnic minorities. By definition, refugees differ from the usual immigrant in that they have been forced to leave their native countries and usual places of domicile because of persecution and cannot return because of a fear of persecution. Their pre-migration and migration experiences invariably have been extremely traumatic, further compounding the usual problems of resettlement and

adjustment in a foreign country and culture. Many have been separated from family and friends; indeed, many refugees are surviving members of families, factors that contribute to despair, depression, and guilt.

The recent refugee immigration differs from past waves of immigration which were predominantly from European and Caucasian countries. Since 1975, over a million refugees have arrived in the U.S. In contrast to earlier refugees and immigrants, the latest refugees are predominantly from nonEuropean and nonCaucasian countries such as the Southeast Asian countries (from which about 75 percent of the refugees have come), Cuba, Haiti, Ethiopia, and Afghanistan. Thus, most refugees bring with them a non-western language, culture, and outlook on life that may include a non-western perception of physical and mental health and of how physical and mental illness are to be treated. Most of the refugees, being nonCaucasian, also become victims of racial discrimination, both the blatant and overt prejudices, biases and hatreds of personal racism and the subtle and pervasive forms of institutional racism of policies, systems, and practices that perpetuate or exacerbate racial inequality.

There has been a great deal of romanticizing of the refugee experience, particularly by television, which, understandably, usually portrays the success story of dramatic achievement against heavy odds. The "first decade of refugee resettlement" was marked by a sense of compassion, humanitarianism and responsibility toward people who had supported the U.S. in a war effort and who suffered as a consequence. The few instances of reported difficulty, such as the harassment of refugee fishermen in Texas, interracial conflicts between white and refugee youth and the conflicts between refugee and other minority

groups over the limited supply of low cost housing, received little attention and generally suggested a sympathetic attitude toward the refugees.

The reality is less romantic. Refugees are having extreme difficulty in moving into the mainstream of American life. Unemployment rates are high and employment tends to be in the "secondary labor market" characterized by low-paying, irregular work and few or no fringe benefits such as paid sick leave and health insurance. Although English language skill is a strong predictor of successful adaptation and adjustment, enrollment in and successful completion of English-as-a-Second-Language classes and acquisition of English show less than promising results because of the fundamental differences between English and most refugee languages, curtailment of ESL classes, the need of refugees to work and some resistance to language and employment training for fear of jeopardizing welfare eligibility.

A troublesome aspect of the refugee population is the very high welfare dependency rate. The refugee population is a "welfare prone" population made up of young families with large numbers of young children, headed by family heads who lack the language, education and occupational skills needed in this country. Although refugee resettlement has always emphasized employment and self-sufficiency, the welfare dependency rate remains stubbornly high. In a sense, perhaps this also can be viewed as a legacy of the refugee experience, the long years many refugees languished in refugee camps before being resettled.

Problems of Acculturation: The Second Decade of Refugee Resettlement.

As the U.S. moves into the "second decade of refugee resettlement", refugees, as a group, appear to be merging into and viewed as members of other immigrant groups and racial minority groups despite experiences that set them apart from other immigrants and minorities. There also is evidence that many refugees are becoming part of the low-income population that is disproportionately made up of children, racial minorities and the working poor. Associated with low income and race, in fact and public perception, are such indicators of personal and social disorganization as crime and delinquency, family violence, adolescent pregnancy, and family dissolution. Refugee youth are known to be a very high risk group. There also is evidence that refugees are being viewed as part of the "welfare problem". As the federal share of financial responsibility is shifted to the states and as the bulk of refugees become "time expired", the states and localities will have to assume a greater share of the financial burden of refugee resettlement. It could well be that attitudes toward refugees will shift from a view of refugees as deserving people who have suffered and who are having problems adjusting in a new country to a less sympathetic view of refugees as problems.

Thus, the mental health services for refugees, and the training of staff to provide such services, must take into account the socioeconomic reality of refugee life in the U.S. as well as the cultural differences and the problems of adjustment and acculturation. In some respects, the problems of refugees have similarities to the

problems of other racial minorities who, also, tend to be of lower income, have more physical and mental problems than do white, middle class Americans and are unserved, underserved, or inappropriately served.

Generalizations across refugee groups must be made cautiously, even across groups from the same general geographical area, despite the tendency to do so since most refugees are from Southeast Asis and all refugees share the common refugee experience of persecution and forced migration. Moreover, once in the U.S., refugees are not only culturally different people, they are acculturating people who are acculturating at vastly different rates, among the different refugee groups, within the groups and even within families. The conflicts are not simply between the majority society and the refugees. There are conflicts between individual refugees and their own ethnic communities, between men and women, between parent and child and between husband and wife as the acculturation process takes place in a dynamic society that is itself in a process of rapid social change.

Such cultural change and its consequence are illustrated in the school system. In a Head Start program in which a large number of Southeast Asian children of refugees was enrolled, Head Start staff were impressed by the progress of the refugee children who learned English rapidly and soon became thoroughly "Americanized". Although Head Start programs emphasize parental involvement, it was observed that parents became involved only with aggressive recruitment, adaptation of the program to be more sensitive to the refugee culture and use of refugee parents in the program as volunteers and paid staff. Various kinds of intergenerational conflict also were reported by

school staff, for example, among adolescent refugee youth. Adolescent girls, in particular, were caught in a bind. Their parents pushed them toward marriage, while they were still "young, pretty and of marriageable age"; the school staff tried to convince the girls to continue in school and postpone marriage and parenthood. At the same time, parental authority is being weakened and role displacement is taking place as refugee youth acculturate more rapidly than their parents.

Most refugee mental health training programs seem to be based on a "cultural differences" model that emphasizes the differences between cultures and attempts to prepare trainees to work "cross-culturally". The cultural differences between the refugee and majority cultures are, of course, real and great. However, given the rapid but uneven rates of acculturation among and within refugee groups and families in a modern industrial society, an alternative "cultural change" model might be considered, one that is premised on the acculturaton process; its dimensions and differential impact on refugee groups, families and individuals. Such a "process" model of training would be more difficult to construct in use in developing curricula and training content but it might be a closer representation of the reality of refugee life in the U.S. since the U.S. is now in the second decade of refugee resettlement, most refugees have been in the U.S. for a considerable period of time and most of their children have either lived most of their lives in the U.S. or are American-born.

ATTACHMENT E: Howard University, Concentration in Displaced Persons

Howard University
School of Social Work
Washington, D.C. 20059

(202) 636-7300

Contact person: Fariyal Ross-Sheriff, PhD., Coordinator

Program Title: Social Work with Displaced Populations

Trainees: Masters level students working with refugees and displaced persons.

This practice concentration within Social Work includes course work, supervised field training experiences and opportunities to conduct research concerning displaced populations. It addresses the critical needs of uprooted populations at the international and domestic levels. The concentration encompasses cross-cultural perspectives, opportunities for dealing with issues including hunger and poverty, unequal resource allocation, refugee problems, and social development. It considers a broad range of social problems and opportunities for social work interventions including practice with individuals, families, groups and communities. It also addresses administrative, planning, and social policy strategies.

Two specialized courses are offered in consecutive semesters:

1. The first course provides a framework for understanding and analyzing problems, issues, and the social work practice implications related to displaced populations. Socio-cultural, political, and economic factors related to these populations are examined.

2. The second course provides an in-depth analysis of social policies, programs and intervention strategies used by a wide variety of service providers, institutions, and self-help groups. Social

policy issues related to discrimination, availability of services, the legal status, and the treatment of displaced populations are examined. A critical analysis of governmental and voluntary programs is presented, and social work interventions, concepts, and practices are studied.

The program is primarily for a master's level concentration for students committed to careers in working with refugees and displaced persons but a bachelor's level survey course is also offered. Continuing education courses are available for individuals already working in the area who have no formal training or preparation. Doctoral level courses in policy, research, and new forms of intervention directed to refugees and displaced persons are being considered.

Reference:
Ross-Sheriff F (1986, Fall): Social Work with Displaced Populations. Howard University, School of Social Work

ATTACHMENT F: Columbia University-Hunter College Social Work Course on Refugees

Columbia University School of Social Work
McVicker, 622 West 113th Street
New York, New York 10025

(212) 280-3409

Contact person: Diane Drachman, DSW, Principal Investigator

and

Hunter College School of Social Work
129 East 79th Street
New York, New York 10021

(212) 570-5061

Contact person: Angela Shen Ryan, DSW, Co-Project Director

Program Title: Social Work Practice with Refugees

Trainees: Students in the graduate social work program

Columbia University and Hunter College received a grant from NIMH in the fall of 1986 to develop a curriculum for a refugee-specific training program at the graduate level. This was in response to the widely recognized need for increasing numbers of professionally prepared social workers trained to provide mental health services to refugees.

A semester long course was developed and offered in the spring of 1987 at each of the two Schools of Social Work. It is projected that the course will be added to the elective offering at both schools.

The course is based on the assumption that practice knowledge with refugee populations is specific and includes an understanding of the departure, transit, and resettlement experiences, i.e.,

"migration/integration as process". The course is organized around a framework that facilitates an:

- analysis of the political, social and economic conditions prior to migration
- understanding of the transit experience and the relation of those experiences to resettlement
- analysis of resettlement in the United States
- analysis of the relation between developmental life stages and the refugee experiences
- analysis of refugee specific helping approaches and implications for direct and indirect practice.

An important aspect of the course was the inclusion of guest lecturers, themselves social work professionals from the refugee communities, engaged in providing services to their own refugee groups. Practice materials were developed which reflect issues related to different views on health, mental health, help-seeking behavior, entitlement, support services, traditional healing systems and their implications for Western clinical practice, program development, and the delivery of culturally appropriate services.

In addition to the incorporation of refugee content into the curricula of graduate school work education, the training grant should enhance the development of new knowledge about different refugee groups, and increase and improve the mental health services to refugees.

A concerted effort is underway toward the development of additional curriculum materials to support the academic and field work

training. Case materials, anecdotal experiences, and clinical insights gained from practitioners are being sought.

A newsletter related to the project has been developed and a one-day national conference, "Refugee Mental Health: Reflections and Directions", was offered. Both activities were carried out as a means of informing the social work community of a model for enhancing social work training programs.

References:

Newsletter from Columbia University and Hunter College Schools of Social Work, entitled, "Refugees and Social Work Practice". Vol 1, No. 1, 1987.

Reports from Diane Drachman and Angela Shen Ryan, Project Directors

ATTACHMENT G: Boston University, Continuing Education in Social Work, Refugee and Immigrant Training Center (formerly The Southeast Asian Training Program)

Boston University - School of Social Work
Division of Continuing Education
264 Bay Road
Boston, Massachusetts 02215

(617) 353-3756

Contact person: Kay Jones, MSW, Project Coordinator

Program Title: Refugee and Immigrant Training Center

Trainees: Bilingual, bicultural paraprofessionals, American service providers and MSW students

In 1980, the Southeast Asian Training Center, now the Refugee and Immigrant Training Center, began in response to the growing numbers of refugees in the New England area and the increasing need for training for service providers. The Center addresses the training needs from four perspectives: 1) training for bilingual, bicultural paraprofessionals; 2) training of American service providers; 3) MSW education of students from the refugee community; and 4) production of training materials.

The training program for refugee paraprofessionals is targeted to those employed in voluntary agencies, public agencies, mental health, and hospital settings which serve refugees. More recently, case manager training, mental health aide training, and advanced practice in casework and community work for bilingual/bicultural workers have been developed.

For the bicultural paraprofessionals, the adult education model is employed with the curriculum of the training program defined by the nature of job functions of the students in their agency of employment.

These include direct work with individuals and families, advocacy, information and referral, and cultural interpretation of client behavior to mainstream staff. Information on the formal social service structure and regulations of importance to agency-based workers is presented. Much stress is placed on the less explicit need for bilingual workers to learn how to listen and to act when helping clients and how to focus on the accomplishment of specific tasks. How to set limits in relation to demands from the refugee communities is also stressed. In response to agency needs, an intermediate course on Southeast Asian human service workers is offered for those with two years work experience and previous training.

For Western mainstream service providers, the Center offers one and two-day workshops for social workers, teachers, and medical personnel. These workshops include information about the refugee cultures, services of voluntary agencies and mutual assistance organizations working with refugees, policy and procedural changes within agencies to improve services to refugees and, in addition, programming for the special needs of agencies providing services to refugees. For human service professionals supervising bicultural staff, a twenty hour course is offered that focuses on administrative and supervisory functions.

At the MSW level, Boston University has a training grant to provide tuition and stipends for refugee students. In this program, educational supports are provided through faculty advising, language and writing skill assistance and student group meetings. The students in this program are committed to practice in mental health services upon graduation, as repayment of their grants. Refugee-related

practice materials are being developed for inclusion in the overall MSW curriculum.

A manual for supervisors and trainers, A Mutual Challenge -- Training and Learning with the Indochinese in Social Work, has been published and provides an excellent guide for those who would want to establish a similar training program. The manual was the result of an initial program to address the training needs of bilingual Indochinese who were serving as translators when it was realized that translation alone was not sufficient for appropriate assessment of the needs of refugees to provide necessary services.

The 150 pages of the manual include material on: background knowledge for work with Southeast Asian paraprofessionals; the refugee experience; adaptation to a new culture; understanding other cultures; the bicultural paraprofessional role; adult education and supervision; the adult education model in cross-cultural education and the supervision of bicultural paraprofessionals. The manual concludes with a five chapter section on curriculum materials and training.

Reference:
Lique KH (Ed.) (1982): A Mutual Challenge - Training and Learning with the Indochinese in Social Work. Boston: Boston University, Boston University School of Social Work.

ATTACHMENT H: Cultural Psychiatry Education During Psychiatric Residency
(Note: This paper is a pre-publication draft of an article in press for the Journal of Psychiatric Education.)

CULTURAL PSYCHIATRY EDUCATION DURING PSYCHIATRIC RESIDENCY

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CULTURAL PSYCHIATRY EDUCATION DURING PSYCHIATRIC RESIDENCY

ABSTRACT

At a time when more important information is known about cultural influences in psychiatry, a survey indicates that markedly less is being taught residents on this subject. Problems in defining what needs to be taught and how to do it are discussed. It seems that an emphasis during PGY 1 and 2 on the cultural identity of the residents themselves will stimulate them to become more interested in the theoretical and practical issues which can be presented in the PGY 3 and/or 4 years.

CULTURAL PSYCHIATRY EDUCATION DURING PSYCHIATRIC RESIDENCY

As the amount of psychiatric knowledge increases and the period of residency remains constant, there are bound to be problems in incorporating all the relevant educational areas. Not long ago, Borus (1) pointed out that administration was one such neglected area. Another may be cultural psychiatry.

But first, what are we talking about when we use the term "cultural psychiatry"? The American Association of Directors of Psychiatric Residency Training (A.A.D.P.R.T.) has used the related terminology of "minority/transcultural issues". These and such terms as ethnicity, socioeconomic, and community may have more than semantic differences. They can imply not only our potential area of educational concern, but also the path that may be most helpful to follow in order to learn the material.

The word "culture" itself has come to be used with so many different meanings that it often creates some confusion. (2,3) One common meaning derives from the anthropologists, who used culture to designate all the modes of belief and behavior of a tribe or people. Apropos to our concern, this view of culture can refer to so-called minority, ethnic, racial, or religious groups like Black-Americans, Mexican-Americans, or Asian-Americans. In American society in general, spurred on by the civil rights and other ethnic movements of the 1960's, we have witnessed a revitalized adherence to diverse ethnic traditions. (4) More recent immigrants from Central America, Asia, and elsewhere is increasing the cultural heterogeneity. However, the public has also used the term culture in other, perhaps related,

senses. It can refer to certain kinds of artistic expression, such as the artistic traditions of Western Europe as reflected in classical music, opera, ballet, and theatre. It can also refer to alternative social practices, as in counterculture. In a broad developmental perspective, Winnicott (5) states that cultural experience starts "in the potential space between a child and mother when experience has produced in the child a high degree of confidence in the mother" and is first seen "as play, and leads on to the whole area of man's inheritance, including the arts, the myths of history, the slow march of philosophical thought and the mysteries of mathematics, and of group management and of religion". In all its current manifestations, culture can now denote almost any chunk of social reality you like - or dislike.

If psychiatry doesn't try to add on yet another definition, then cultural psychiatry in its broadest sense can then denote any chunk of social reality that the psychiatrist or patient likes - or dislikes. Far from being useless in its imprecision, this definition implies the need for training in cultural psychiatry and its interest to all psychiatrists. (6) As Segall (7) states, "I want us to be as unconstrained as possible by defitional strictures when we engage in the search for the ecological, social, and cultural phenomena that shape and in turn are shaped by human behavior in all of its diversity and sameness the world over".

Fortunately or unfortunately, depending on the situation, psychiatry has not been found to be culture free. Abundant research and reflection has indicated that patient care is affected in numerous ways by our like or dislike of certain social groups. (8,9,10) This

can be found in beginning residents, as illustrated by a study that showed the preference of black and white psychiatric residents to follow patients of their own racial group. (11) The preference of psychoanalytic psychotherapists for the YAVIS patient - young, attractive, verbal, intelligent, and successful - is well known and will exclude cultural groups of patients, depending on the culture of the clinician. Publicity has been made recently of the avoidance of psychiatrists of chronic patients. V.I.P.s often receive as compromised treatment as poor minorities though, to be sure, in nicer settings.

Even when clinicians are neutral about the culture of their patients, culture can influence the presentation of symptoms, the diagnostic process, and the response to treatment. (12) The Amish study links culture not only to social relationships, but to all aspects of the biopsychosocial model. (13-17)

Even the broadening cultural background of current psychiatrists has not corrected these biases. For one thing, even if enough manpower existed, not all psychiatrists will want to treat predominantly patients from their own cultural groups (and vice versa for patients). For another thing, there may be a "whitening" effect of residency training. (18) In addition, prior likes and dislikes have influenced research and the dissemination of relevant cultural knowledge. (19) Much cross-cultural research is about cultures outside the United States, and one can be left with the impression that culture is "exotic" and outside our immediate concern. We tend to ignore such "hidden" cultural groups within the United States as the Cape Verdeans, Lithuanians, and numerous American Indian tribes. (20, 21) Researchers

are belatedly just starting to learn about racial variations which may influence psychopharmacology. How well do we and our graduates understand the nuances and psychodynamic complexity of using interpreters when language difference exist. There has also been a paucity of research on repercussions when the patient and psychiatrist come from similar cultural backgrounds. (22)

CURRENT STATUS OF CULTURAL PSYCHIATRY TRAINING

Over the past decade, a recognition of these issues has evoked periodic concern and guidelines for rectifying the problems. (23-26) All of this thrust is reflected in the 1984 document "Special Requirements for Residency Training in Psychiatry." On didactic instruction, it states that "the curriculum should contain enough instruction about these issues to enable residents to render competent care to their patients from various cultural backgrounds." Moreover, as far as clinical experience, it states that residents "must have supervised experience in the evaluation and treatment of patients of both sexes, of various ages from childhood to old age, and from a variety of ethnic, racial, social, and economic backgrounds."

It appears that actual education in cultural psychiatry may be falling far short of this recommendation. In 1977, the American Association of Directors of Psychiatric Residency Training (AADPRT) sent questionnaires to all psychiatry residency programs, asking questions regarding each program's curriculum. Cultural issues were surveyed via a question on the presence or absence of a course on "Minority/Transcultural Issues". The overall response rate to the 1977

survey was 50% (110/220), and the response rate within that 50% to the question on minority/transcultural issues was 80% (90/110). At that time, 42 programs stated that Minority/Transcultural Issues were not covered in their curriculum. However, 36 programs stated that the topic was included in another course and 12 other programs stated that they offered a special course on Minority/Transcultural Issues.

In 1984, a followup study was conducted by Kelly Reid, M.D. (with the help of Zebulon Taintor, M.D.) on those 48 programs known to teach something about cultural psychiatry. The survey was designed to assess how the numbers of those courses have changed since 1977, what material is being taught in these courses, how it is being taught, what approaches to teaching the subject work, and which approaches don't seem to work. (The findings were presented at the January, 1985 meeting of the AADPRT at the workshop on Minority Issues chaired by Jeanne Spurlock, M.D., at the 1986 meeting as part of a workshop on Teaching Cultural Psychiatry led by the authors, and as part of a proposed model curriculum reviewed by the cultural subcommittee of the AADPRT.) The overall response rate to the 1984 survey was 62% (30/48). Of the responders, more than 40% indicated that the "special courses" on Minority/Transcultural Issues have been discontinued (5 out of 12), and 50% of the respondents who previously had taught the subject as part of another course had discontinued it (9 out of 18). The reasons cited were loss of funding and loss of faculty. Overall, this shows a striking mortality rate in courses that seem to teach some aspect of cultural psychiatry.

Those respondents still teaching about cultural issues mentioned a variety of educational approaches. As to length of the courses, it

should be noted that some of the programs which taught Minority/Transcultural Issues as part of another course actually had longer, more detailed curricula than those programs which stated they offered "special courses" on this topic. The course lengths ranged from 1-2 week seminars during one year of residency, to a three month weekly seminar series during one of the four years, to giving at least five seminars throughout each year of the residency training. The issue of length and placement of the course was felt to be important, in the sense that more prolonged exposure to the material added to the impact of this topic on the residents. As to the content of the courses, two programs offered courses which were geared solely towards the acculturation of FMG's, including such topics as "Melting Pot: Myth or Reality?" Topics covered in programs not oriented toward FMG's included the following: therapy issues of major minority groups, cultural factors that impact on health beliefs and health seeking, transference and countertransference issues, and the influence of individual or institutional racism on the psychiatric evaluation and treatment process. One program centered its whole curriculum around an "experiential", or process group format, which included faculty members' personal cultural experiences as well as the residents'. In general, it was felt that there was still not enough emphasis on this topic in the curriculum.

THE BAYLOR EXAMPLE

A consideration of the literature and survey presents a dilemma. Cultural psychiatry training appears to be drastically decreasing at a

time when it may be needed more than ever and when there seems to be almost too much to teach. At the Department of Psychiatry, Baylor College of Medicine, a working model has emerged to address this dilemma.

Cultural psychiatry training at Baylor has evolved over a five year period to this current model. Having the sanction of the Department and the support of the Residency Director to develop a longitudinal curriculum, the two seminar leaders initially experimented on a combination of approaches geared to exploring the influence of the cultural background of clinicians as well as the cultural background of patients. However, from the residents' feedback and observation of their comprehension, it soon became apparent that the introduction of theoretical and practical information early in the residency training was ill-timed, and the following model developed.

Recommended Training Experiences

Opportunities to teach cultural psychiatry can be built into the usual sequence of training experiences for psychiatric residents without extra funding. Paying attention to the cultural aspects of the usual clinical experiences and supplementing this exposure through a graduated seminar series can provide a simplified, yet sophisticated, approach to cultural psychiatry training. Inherent in this proposal is the ideal notion that this training should occur thgoughout the PGY 1-4 years, but with provisions for residents who might only be exposed to an isolated one to two years of a particular program. The advantage of the longitudinal exposure is the increased likelihood of "working

through" this complex topic at a progressively more sophisticated level.

In the PGY 1 and 2 years, most residents are exposed to patients in such settings as the emergency room, inpatient unit, and consultation-liaison services. There are often public patients from a wide variety of cultural backgrounds. Before appropriate care can be provided, effective communication and a therapeutic alliance must be established. Culturally sensitive supervision can help reduce the residents' fear and confusion in interacting with people whose experiences and values may be foreign to the resident. In addition, supervisors can try to ensure that residents do not unduly drift toward caring for patients from cultures that they feel most comfortable with. During both PGY 1 and 2 years, the cultural components of patient care should be introduced gradually and geared to the resident's mastery of basic assessment and treatment skills; that is, a resident may find it difficult to appreciate the likelihood of distortions in cross-cultural interviewing if the resident doesn't already have some basic grasps of DSM-III.

To supplement this clinical exposure and help residents to appreciate and assess cultural factors in a person's life, the seminar series can focus on the cultural identity of the residents themselves. (10,27) This activity would be relevant to any resident, whether so-called white, minority or F.M.G. This approach, while not therapeutic in intent, would be akin to residents participating in family-of-origin groups to help them appreciate family dynamics, to participating in process groups to appreciate group psychology, and to that aspect of personal psychotherapy that helps the resident appreciate generic

psychodynamic issues. In the PGY 1 year, perhaps at least five seminars could focus on the cultural identity of residents and faculty by examining five questions: (28)

1. How would you describe yourself ethnically?
2. What person most influenced your choice of ethnic identity?
3. What groups do you feel you understand best other than your own?
4. List three aspects of your group you like the most and three aspects that you like the least.
5. What are your earliest memories of skin color as a factor in your interactions with other people?

In the PGY 2 year, this focus could be enlarged by having one seminar for every two residents, in order to examine the culture-of-origin of residents and faculty by reviewing and presenting the historical roots of their cultural identity. Faculty can model and reduce undue anxiety by leading the way in the presentations. Faculty can also interject theoretical and practical information when appropriate.

In the PGY 3 year, if child psychiatry and psychodynamic psychotherapy are emphasized, the resident should again be exposed to as wide a cultural patient population as locally possible. If the cultural variation is narrow, caution should be provided against generalization to all cultural groups. Whenever a community psychiatry rotation is provided, residents should be exposed to the outpatient treatment of poor patients, and come to understand why community mental health developed in part to improve the treatment of such patients. By

now, the resident should have enough basic psychiatric knowledge to integrate the cultural influence. Therefore, the seminar series can focus on theoretical material and practical issues in patient care. By allowing each resident to present on patient care issues relevant to a cultural group of their choosing, local cultural variation will be taken into account and a model for learning about other cultural groups illustrated. Faculty can supplement these presentations with others on more generic issues, such as cultural factors in psychodynamic pyschotherapy, as well as lecture on the necessary theoretical background. The PGY 4 year can be reserved for electives.

It may be apparent that some of the material could be integrated into seminars of other core psychiatric topics, such as interviewing, psychotherapy, and child psychiatry. Hence, an alternative is a combination of a separate seminar series in cultural psychiatry and some integration in other seminars.

The cultural educators need not be "experts" in cultural psychiatry to lead the suggested seminars and provide supervision. Rather, an interest in the area and skill in leading process type seminars would seem to be the necessary qualifications. If competent faculty are not available, experts in the field can be invited to provide workshop training.

A Resident Illustration

In the PGY 1 seminar, this participant (based on a real resident) might give a cultural identity as an American Jew (male), but describe the ambivalence in sharing that publicly. In response to questions,

the difference between that designation and American Jew (female), Jewish American, Jew, or American was discussed. Although positive feelings were expressed for the family life and education, the participant had always felt pressured by the maternal expectations and competitive environment. The participant recalled early years in a culturally changing neighborhood where skin color assumed importance. While rotating on emergency call, the participant felt vaguely uneasy with the most serious physical and emotional trauma, though not in a diagnostic or treatment sense. Whenever sleep was possible, occasional dreams of being involved in mass catastrophe were disturbing. These dreams seemed to intensify after reading Max Apple's short story on circumcision, "The Eighth Day". After discussion with a supervisor, the participant still wasn't quite sure if this derived from Oedipal counter-transference or normal culture-bound paranoia.

In the PGY 2 seminar, the participant would trace personal culture-of-origin only back to the turn of the century. At that time, grandparents had come from Europe. Later, the extended family was apparently eliminated in Europe during the Holocaust, while the family attempted to become American and forget the past. Age, the significance of generation, and the original settling of the family in urban New York was discussed.

In the PGY 3 seminar, this participant chose to present Black-Americans. From an emic/etic theoretical framework, (29) they were described in terms of their slave history in America, subsequent distrust of "whites", the common misdiagnosis of paranoid schizophrenia and antisocial personality, the occasional use of "being oppressed" as an avoidance of a deeper psychological issue and the relative lack of

provision of psychoanalytic psychotherapy to this group. While learning to do psychotherapy, this participant had a higher than usual number of minority group patients, came to realize the danger of rescue fantasies, and worked on an aversion to V.I.P. patients.

In the PGY 4 year, this participant elected to study the psychological meaning of the winter holidays to different cultural groups. After so doing, the participant recommended that the multicultural clinical site have a series of holiday celebrations: A December festival focusing on the Christian, Jewish, and native Mexican cultures; a January festival celebrating American New Years and Martin Luther King's birthday; and a February celebration of the Chinese New Year and Valentine's Day.

Evaluation

So far, the cultural psychiatry training program at Baylor has used the same evaluation tools as the other educational areas. Principally, these include mutual feedback as well as a new resident seminar evaluation form filled out by the most current group of PGY 1 and 2 residents. The latter consists of items on a 5 point scale as well as room for comments. As a group, both resident groups suggested the cultural seminars were of high value. For instance, on the questions, "Before beginning this seminar, my interest in the subject matter was . . ." provided an average response of 3 (about average). Then, for the following question, "After completing this seminar, my interest in the subject matter is . . ." provided an average response of 4 (high). Comments provided by more than one resident included

liking the example of the faculty being open in the presentation of their own cultural backgrounds and the leader's use of humor. An indirect comment on the impact of the cultural training may be reflected in the Journal Club presentations. In these monthly evening presentations at a faculty member's home, a resident picks a topic to research and present. For the groups of residents before the formal cultural training program, a presentation on a cultural psychiatry topic was extremely rare. In contrast, out of the past 10 Journal Clubs, about 40% of the presentations were on a cultural psychiatry topic.

Besides these evaluation components, other methods can and should be used. For more objective feedback, a variety of cognitive approaches can be used. For instance, after the PGY 3 year, evaluation could consist of a multiple choice test format on cultural knowledge developed by each presenter. Skills can be assessed through such modalities as serial videotape interviews. Since attitudinal issues seem so important in cultural psychiatry, this area should not be ignored in evaluation. Besides the assessment by faculty, a pre and post questionnaire could be designed to tap into this area. This has been done for such related areas as community psychiatry. (30,31)

DISCUSSION

At a time when it appears to be needed even more, data indicate that the cultural aspects of psychiatric practice are being ignored by most residency programs. This neglect is despite research which shows that cultural psychiatry training can potentially improve the mental health care of patients from any cultural background. (32,33) Reasons for the lack of training are uncertain, although inadequate funding and the inaccurate perception that cultural concerns are trivial, commonsensical, or pseudoscientific are posited. (34) Those training endeavors that are known to exist are highlighted by a lack of consensus. Although residents seem to be coming from a broader cultural background, the lack of cultural training may have allowed a "whitening" process to effect all residents. (18)

In order to overcome these obstacles, training in cultural psychiatry would seem to require a recognition and appreciation of the omnipresence of "culture" in psychiatric evaluation, treatment, and research. Culture does not just refer to "exotic" groups living outside the United States or to "minority" groups within the United States. To make the education practical for all residency programs, and by implication to continuing education programs in psychiatry, this omnipresence can be translated into two essential objectives. The first objective would be to develop the cultural identity of each psychiatrist. This objective might help the residents to appreciate the cultural backgrounds of the patients, as it is unlikely that they would naturally recognize the importance of cultural psychiatry as they would psychotherapy or psychopharmacology. An appreciation of their

cultural identity would then prepare them to appreciate and be interested in the theory, skills, and knowledge necessary to practice culturally sensitive clinical care. (35) These skills and knowledge would be referenced to national concerns and "local color". (36) While prior formats for psychiatric workups did not particularly lend themselves to incorporating cultural data, a new comprehensive psychiatric formulation model has a distinct section for "sociocultural characterization". (37)

Besides the Baylor example, other teaching tools could be used to achieve the same goals. For the experiential components, family photographs, going to ethnic restaurants, discussing the values of one's grandparents and reading fiction, could also be used. The goal of any of these exercises would be to avoid the stereotyping which is often the by-product of discussing general groups like "Black-Americans". Overcoming stereotypes of our perceptions of cultural groups is not easy, since they seem to stem from such basic intrapsychic developmental anxieties as "good/bad" self/object, and the stereotypes have come to permeate literature, fine arts, popular arts, science, and medicine (especially psychiatry) since the Middle Ages. (38) After all, we want residents to appreciate and be interested in the influence of culture on the mental health of individual patients. As Adams (39) has said, "An understanding of individuals and families interplaying against an intimate subculture, over several years and generations, is more fruitful for psychiatric work than any facile stereotyping by class, gender, race, and religion". Depending on the cultural sophistication of the group, more theory could be introduced earlier. Any formal educational program

will need the support of the Residency Director and Chairman, as well as the expectation that the topic will not seem relevant to some faculty.

The rewards of meeting this challenge may be numerous. Myths and misconceptions can be corrected. Greater diagnostic precision and accuracy is obtained when clinicians can clearly distinguish between symptoms and signs that are manifestations of psychiatric abnormalities versus those that represent sociocultural differences between the belief systems of the patient and the clinician. A greater degree of compliance with treatment recommendations may occur when patients and their families believe that their own beliefs are being respected and adapted to as part of the treatment process. The understanding of the psychiatrist's own culture - while intuitively known to some degree - becomes more cognitively accessible, thus rendering it a more useful everyday tool of the developing resident whose skills are being ever sharpened.

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34. Kleinman, A. M.: Rethinking the social and cultural context of psychopathology and psychiatric care, in Renewal in Psychiatry: A Critical Rational Perspective. Edited by Kleinman, A. M., Manschrek, T. C. New York, John Wiley and Sons, 1977.

35. Erikson, E.: Childhood and Society, New York, Norton, 1950.

36. Collins, J. L., Mathura, C. B., Risher, D. L.: Training psychiatric staff to treat a multicultural patient population. Hospital Community Psychiatry 35: 392-396, 1984.

37. Faulkner, L. R., Kinzie, J. D., Angell, R., et al: A comprehensive psychiatric formulation model. Journal of Psychiatric Education 9(3): 189-203, 1985.

38. Gilman, S. C.: Differences and Pathology-Stereotypes of Sexuality, Race, and Madness. Ithaca, Cornell University Press, 1985.

39. Adams, P.: The WASP Child, in Basic Handbook of Child Psychiatry I. Edited by Noshpitz J. D. New York, Basic Books, 1979.

UNIVERSITY OF MINNESOTA

CROSS-CULTURAL PSYCHOLOGY: ISSUES AND METHODS OF STUDY

SYLLABUS

Winter Quarter

1988

Course Meetings : Tuesdays 4:00 to 6:00
N427 Elliott

Instructors : Dr. James Butcher
Dr. Joseph Westermeyer

Credits: 3

STUDENT PROJECTS

Students will choose a topic for research during the first week of the quarter. This topic will be described in a 20 - 25 page term paper due at the end of the quarter.

Suggested strategies for research and/or review:

1). Review the past research that has been published in the area; not necessarily to locate all the papers but the key studies in the area.

2). Select several studies that highlight pertinent methodological or theoretical problems to use as examples in the review.

3). Focus the review and presentation on several aspects of the area:

a. describe the problem area and research goals

b. salient methodological problems

c. describe the range of research methods employed in the area

d. summarize the current status of the empirical research

e. highlight particularly effective or unique research designs

f. give an overview summary of the research; including limitations of previous work, culture boundness of the findings; suggested new directions; etc.

g. provide a reference list.

COURSE OUTLINE

Week One: January 5, 1986 : Overview of cross-cultural psychology.

Importance of the cross-cultural method in psychological research.

Historical landmarks in cross-cultural psychology

Basic definitions and conceptual foci:
culture, enculturation, socialization
the emic-etic distinction

Illustrative approaches to the cross-cultural study of personality:

Methodological limitations in cross-cultural research

The search for " Universals"

Problems in defining cultural variables

Problems in design of controlled studies

Refinement of conceptual dimensions

Sampling problems

Design of comparable measures

Role of instructions

Linguistic assurances

Equivalence in cross-cultural research

Meaning of equivalence

Types of equivalence

Linguistic and psychological equivalence

Methods of assuring cross-cultural equivalence

Readings: Chapter 2 and 4

Required Textbook : Lonner, W. and Berry, J. W. (Eds.), (1987). Field methods in cross-cultural research. Beverly Hills: Sage Publications.

Week Two: January 12: Value of cross-cultural research

Cross-national validity of MMPI scales and factor dimensions

Reading : Chapter 8 in the Text.

Additional Readings:

Butcher, J. N. and Pancheri, P.(1976). Handbook of cross-national MMPI research . Minneapolis: University of Minnesota Press. Chapter I.

Butcher, J.N. Cross-cultural research methods in clinical psychology. In P.C. Kendall and J. N. Butcher (Eds.) Handbook of research methods in clinical psychology . New York: Wiley Interscience, 1982.

Week Three: January 19, 1983

Cross-cultural study of abnormal personality. Dr. Rosa Garcia

Generality of diagnoses cross-culturally

Reading:

Al-Issa, I. (1982). Does culture make a difference in psychopathology? In I.Al Issa (Ed.) Culture and psychopathology. Baltimore: University Park Press.

Garcia-Peltoniemi, R. (1987). Psychopathology in refugees. (Contract # 278-85-0024 CH). Washington, D.C. National Institute of Mental Health.

Week Four : January 26, 1983

Psychiatric diagnosis, psychopathology, and psychiatric epidemology — Joe Westermeyer

Readings:

Westermeyer, J. (1985). Psychiatric diagnosis across cultural boundaries. American Journal of Psychiatry, 142, 798-805.

Westermeyer, J. (1987). Clinical considerations in cross-cultural diagnosis. Hospital and Community Psychiatry, 38, 160-164.

Week Five : February 2, 1987

Assessment and Treatment of refugees: Use of translators in clinical work — Eric Egli

Reading: Ch 5 of text.

Week Six: February 9, 1987

Cross-Cultural Research Methods: — Yosef Ben-Porath

Part 1: Use of Factor Analysis in Assuring Equivalence

Part 2: Stressors in adjustment

Optional Reading:

Ben-Porath, Y. (1987). Issues in the psycho-social adjustment of refugees. (Contract # 278-85-0024 CH). Washington, D.C. National Institute of Mental Health.

Week Seven: February 16, 1987

Mental Health of Refugees — Dr. Carolyn Williams

Readings:

Williams, C.L. (In press). Prevention programs for refugees. An interface for mental health and public policy. Journal of Primary Prevention.

Williams, C.L. (1985). The southeast Asian refugees and community mental health. Journal of Community Psychology, 13, 258-269.

Week Eight: February 23, 1987

Cross cultural study of Personality — Noriko Shiota

Week Nine: March 1 st, 1987 Discussion Topics

Week Ten: March 8th, 1987 Discussion Topics

References

Brein, M. and David, K.H. (1971). Adjustment of the sojurner. Psychological Bulletin , 76,215-230.

Draguns, J. G.(1982) Methodology in cross-cultural psychopathology. In I. Al-Issa (Ed.) Culture and psychopathology. Baltimore: University Park Press.

Harrington, C. and Whiting, .W. (1972). Socialization process and personality. In F.L.K. Hsu (Ed)Psychological Anthropology Rev Ed. Cambridge, Mass.: Schenkman, Pp 469-508.

Hsu, J.and Tseng, W. (1972). Intercultural psychotherapy. Archives of General Psychiatry, 27, 700-704.

Lambert, W.W. Comparative studies of personality.(1971) In W.W. Lambert and R. Weisbrod (Eds.) Comparative perspectives on social psychology. Boston : Little Brown and Co.

Taft, R. Coping with unfamiliar cultures. (1977). In N. Warren (ed). Studies in cross-cultural psychology. Volume 1. New

York: Academic Press.

Triandis, H.C., and Berry, J.W. (1980). Handbook of cross-cultural psychology: Methodology (Volume two). Boston: Allyn & Bacon.

ATTACHMENT J: Psycho-Diagnostic Training Clinic

Center for Multi-Cultural Training in Psychology
Boston City Hospital
818 Harrison Avenue
Boston, MA 02118

424-4645, 4646

Contact Person: Gisela Morales Barreto, Ps.Ldo, M.A.
Associate Director
Center for Multi-Cultural Training in Psychology

The Psychodiagnostic Training Clinic

Philosophy and Purpose:

The Psychodiagnostic Training Clinic (PTC) has been designed to meet the needs of the underserved population of the Boston City Hospital area while providing a hospital-based training site for the interns of the Center for Multi-Cultural Training in Psychology and a point of direct input on clinical issues including direct service and supervision of the same for all interns of the Psychology Department, Division of Psychiatry.

The clinic is located on the second floor of the House Officers Building in Boston City Hospital and is staffed by the pre- and post-doctoral interns and fellows of the Center for Multi-Cultural Training in Psychology of Boston City Hospital/Boston University School of Medicine. These interns and fellows have expressed, by their choice of internship, a particular interest in learning effective models for working with the multi-problemed individuals found in most poor, inner-city communities. Thus the clinic's main objective is to provide a wide range of treatment problems to the intern while providing ongoing

supervision and support for the handling of such a psychodiagnostic case load.

An equally important objective of the PTC is to provide quality service to the innter-city community. The clinic provides a unique service in that its staff is comprised of a cross-section of well-trained, multi-ethnic professionals who can provide a unique cultural perspective not found in most clinics serving this kind of population. In serving this population, the psycho-social, often psycho-legal, aspects of the case will be taken into account although the full range of socio-legal services will not be provided. Thus the population which we serve will receive treatment from individuals who will have a greater understanding of and appreciation for the cultural aspects of their difficulties than has usually been the case.

Finally, the PTC serves the objective of integrating more of the institution's Psychology and Psychiatry staff into the training of the interns. Thus the institution's staff will have an opportunity to share their expertise with the trainees as well as affording a forum (through Core Seminar, Network Teaching and Supervision) for discussion of the particular difficulties that this population affords.

Clinic Procedures

I. Referrals

Source: Clients will be referred from within the Boston City Hospital complex as well as from outside community agencies.

Acceptance of Referrals: All clinicians are expected to accept telephone referrals when possible. The information is

to be transcribed onto the referral form and placed in the Clinic Director's Box.

Assignment of Referrals: Case assignments are made by the Clinic Director. Each intern is expected to carry a minimum of one testing per week. The referral form is to be placed into a folder which then becomes the client's PTC record. The assigned clinician is responsible for contacting the referral source for clarifying information. After the completion of the evaluation, a report is to be sent to the referring agent, after obtaining a Release of Information from the client in order to notify the source of the disposition of the case.

II. Appointments:

Appointments are scheduled by the Clinic Director with the client. The Clinic Director will assign cases to interns. Each client will receive two consecutive appintments in order for the intern to complete the evaluation. Interns are expected to check with the Clinic Secretary about their appointments for each Testing Clinic day. Interns are also expected to complete the evaluation in two sessions; however, if the need exists for more time, this should be communicated to the Clinic Director and/or Clinic Secretary in order to make appropriate arrangements.

III. Testing Reports:

The completed test report is due within two weeks of the completion of testing. However, by January, 1987, it is expected that reports will be completed within one week. A

copy of the completed report is to be placed in the client's folder along with the referral form and billing information. A note indicating that the patient was seen and location of the report MUST be entered into the client's hospital record.

IV. Record Keeping:

There are two places in which client information is to be recorded. The client's hospital record is kept in the B.C.H. Record Room, Basement of the Ambulatory Care Center. New clients will have a record in the record room within a week of registration, and the record should be called for as soon as available with previous client contact appropriately noted. The client contact is to be recorded in the hospital record after the first session and after completion of evaluation. In addition, a note is to be entered in the hospital chart whenever there is any medical consultation (including contact with psychiatrist supervisor). The clinic record is to be kept in the Main Office, Rm. 207. It is started with the referral and includes the intake data sheet, intake summary, any reports or correspondence concerning the client and copy of the testing report. Under no circumstances are either hospital records or clinic records to be removed from the hospital.

V. Confidentiality and Client's Rights:

The rights of the client to all recorded information concerning them are to be respected at all times. Once the referral has been made, all interaction with other sources about a particular client must be discussed with the client.

A signed Release of Information is to be obtained before exchange of any written information, and verbal conversations must be discussed with the client. The only exemptions from this policy are discussions with clinic supervisors or staff. The client's permission must be gained prior to video and/or audio taping sessions. Client's requests to see their records are to be honored after discussion with the clinic or testing supervisor.

VI. Testing Supervisors:

The testing supervisor provides supervision of test data and signs off on all supervised test reports.

VII. Psychiatric Supervisors:

Each intern will be assigned a Psychiatrist as medical backup in the event that consultation regarding medication is deemed necessary.

VIII. Patient Statistics:

A monthly patient statistics sheet will be given to each provider in the first week of the month. These are to be filled out and returned no later than ONE WEEK subsequent to receipt of the form. These will be collated and will be used to generate quarterly reports.

IX. Vacation Time:

Interns must plan their vacation time at least two (2) weeks in advance and communicate their plans to the Clinic Director. This will avoid confusion around scheduled appointments.

X. Consultation Referrals:

Interns are placed within the Hospital as consultants to the Division of Psychiatry (Adult Primary Care and Psychosomatic Units), to the Division of Child Psychiatry and Adolescent Center. In this capacity, interns can refer to the Psychodiagnostic Clinic those cases that in their judgment need testing evaluations. Interns must fill out referral forms with the appropriate information and give those referrals to the Clinic Director.

XI. Testing Equipment:

Under no circumstances is the testing equipment to be removed from the Clinic. Testing materials to be used will be checked out and returned with the secretary's approval. Interns will be responsible for the testing materials that they use. Therefore, interns will be expected to replace, at their own expense, any missing/lost materials.

ATTACHMENT K: University of Washington, School of Nursing

University of Washington
School of Nursing
Community Health Care Systems

COURSE TITLE:	Transcultural Nursing Practices
COURSE NUMBER:	CHCS583
CREDITS:	3
CLASS HOURS:	3
PREREQUISITES:	None required, but CHCS562 recommended
PLACEMENT:	Winter Quarter

I. COURSE DESCRIPTION

A comparative analysis of nursing care practices of Western and non-Western cultures with emphasis on theoretical and practice dimensions. Seminar discussions focus on nursing care concepts and practices as these related to values, beliefs, and techniques of nursing viewed cross-culturally. Transcultural caring and curing role behaviors and processes of socialization into these roles will be explored. The subculture of nursing, therapeutic and non-therapeutic effects of nursing rituals, myths, and practices will be examined in relation to care components. Current theoretical and research methods for the study of nursing care components will be an important part of the course.

II. OVERVIEW

"Transcultural Nursing Practices" is the second in four core courses in cross-cultural nursing. This course, conducted by the seminar method, is introduced through utilization of a model of transcultural nursing care. As alternative models become available,

they are incorporated for comparative analysis. Caring and curing practice, and values and beliefs relating to them, of western and selected non-western groups are explored in some depth, including alaysis of one's own value system. Each student selects a non-western cultural group to present in seminar. Student evaluation is based on seminar presentation, class discussion, and a paper related to the selected seminar topic. Course evaluation is carried out by end of course student evaluation, and by faculty members in the cross-cultural pathway.

Transcultural nursing concepts are introduced, drawing on theoretical approaches from nursing, anthropology, and other behavioral sciences, thus striving to meet the first terminal objective for the cross-cultural pathway. Terminal objectives 4, 5 and 6 include valuing transcultural theories and concepts as vital components of the scientific rationale underlying the nursing process, analyzing and synthesizing data relating to similarities and differences in transcultural nursing care beliefs and values, and demonstrating a culturally relativistic value system, are additional foci of this course. To a more limited extent, an introduction to community concepts is included to be developed more thoroughly in CHCS578, "Seminar in Cross-Cultural Nursing".

III. OBJECTIVES

A. Acquire a comparative perspective of, and appreciation for, transcultural variation in nursing care beliefs, values, and practices as

manifested by Western and non-Western cultures.

B. Identify and critically analyze such transcultural nursing care components as nurturance, comfort, support, concern, and helping from humanistic, technical, and scientific perspectives.

C. Examine cross-cultural caring and curing role behaviors, and process of socialization to those roles, in relation to health beliefs and practices.

D. Gain knowledge of the subcultures of nursing and the impact of these on the health care of people whose cultural values may differ from those of Western nursing.

E. Examine common and recurring nursing rituals, myths and magical practices and their consequences for helping clients.

F. Examine critical problems and issues related to practice of nursing transculturally.

G. Determine appropriate research strategies and theoretical models for studying nursing problems transculturally.

IV. COURSE OUTLINE

Unit I - Introduction to model(s) of cross-cultural nursing and research strategies.

A. Origins of development of transcultural nursing

model(s)

B. Analysis of components of the model(s)

C. Utilizing the models in studying nursing problems transculturally

Unit II - Critical problems and issues associated with the practice of nursing transculturally.

A. Introduction into the community

B. Acceptance by the community

C. Strategies to achieve change

Unit III - The subculture of nursing

A. Origin of value system of modern nursing

B. Analysis of Western values and beliefs upon which nursing is based

C. Nursing care rituals, myths, and magical practices

D. Impact of subculture of nursing on health care of people of differing cultural values

Unit IV - Caring and curing among ethnic people of color and selected non-Western peoples.

A. Health beliefs and values of selected subcultural groups

B. Socialization into caring and curing roles

C. Role behaviors of caring and curing persons

D. Consequences of caring and curing practices to health care of clients

The Master of Science in Nursing—Community Health Nursing - Specialization in Cross-cultural Nursing

Purpose

The purpose of the program is to prepare graduate professional nurses who will plan and implement health care programs appropriate to specific populations and cultures, function as culture-brokers between client populations and legislative and administrative bodies involved in the delivery of health programs, and design research studies and health care modalities which illuminate the cultural linkage between cultural attitudes and health seeking behavior. The program focuses on the health care needs of the Hispanic population.

Objectives

The graduate of the program in Cross-Cultural Nursing will be able to:

1. analyze the etiology and prevalence of health problems in particular ethnic populations.

2. communicate and interact effectively with members of particular ethnic populations with regard to health problems.

3. plan and implement population-specific health care programs that are needed by, and acceptable to, particular ethnic populations.

4. communicate from an informed base with local, state, and national bodies concerning issues of health care administration, funding, and policy formulation.

5. analyze the relationship between cultural norms, socio-economic level, and health care practices.

6. design research studies which explore health attitudes and health seeking behavior of particular ethnic groups.

Degree Requirements

Requirements for the Master's Degree in Nursing are found in the Graduate Bulletin of San Diego State University. The M.S. in Nursing requires 42 semester hour credits of study. Spanish instruction especially designed for nurses is provided.

Core Courses

Issues in Nursing & Health Care	3
Theory Development & Nursing Theories	3
Research Methods in Nursing	3
Nursing Care System as an Organization	3
Advanced Research Methods in Nursing	3

Specialization Courses

Epidemiology	3
Social and Cultural Dynamics of Health Care	3
Cross-cultural Nursing Theory	3
Cross-cultural Nursing Practicum	3
Advanced Cross-cultural Nursing Theory	3
Advanced Cross-cultural Nursing Practicum	3
Thesis	3
Electives	6

Admission Requirements

In addition to meeting the general requirements for admission to San Diego State University with classified graduate standing, an applicant must satisfy the following requirements:

- **Have a baccalaureate degree with a major in nursing from a university or college with a National League for Nursing (NLN) accredited program. Graduates from baccalaureate programs not having an upper-division major in nursing or who have academic deficiencies will be considered on an individual basis.**
- **Have a minimum cumulative grade point average of 3.0 in undergraduate nursing courses.**
- **Take the Graduate Record Exam aptitude test and earn 950 or above in combined verbal and quantitative sections.**
- **Submit a photocopy of a current RN license.**
- **Have a minimum of one year full-time experience as an RN in a hospital, ambulatory care or public health facility.**
- **Have satisfactorily completed a 3-unit course in inferential/descriptive statistics. (SDSU Math 250 is recommended.)**
- **Have satisfactorily completed a 4-unit client assessment course or equivalent. (SDSU Nursing 500 is recommended.)**
- **Submit three references addressing applicant's capability to do graduate work.**
- **Submit a personal statement as to professional goals, past accomplishments in nursing, and reasons why applicant wishes to pursue graduate work (limit: two type-written pages.)**

The Community

San Diego State University is situated within a world-famous health care research community with more than 30 hospitals and health centers, which provide diverse clinical placement sites for students.

The University

SDSU is the largest of the 19 campuses in The California State University system offering undergraduate, graduate, and joint doctoral programs.
The University's excellent library and computer services are augmented by computer workshops, computer search facilities, and computer laboratories supervised by experienced personnel. SDSU computer users have access to a powerful statewide computing network centered in Los Angeles.

San Diego State University
School of Nursing, San Diego,
CA 92182-0254 619 229 2706

ATTACHMENT M: University of Texas-Houston, School of Nursing

The University of Texas
Health Science Center at Houston
School of Nursing

Continuing Education

THE INDOCHINESE PROFESSIONAL NURSE LICENSURE PREPARATION PROJECT

The Indochinese Professional Nurse Licensure Preparation Project--subsequently referred to as "NL Prep"--is designed to assist Vietnamese refugee nurses in preparation for the National Council Licensure Examination for Registered Nurses (NCLEX-RN). Passage of this examination would enable these nurses to practice their profession in the United States and thereby make available registered nurses fluent in Indochinese language and culture to give care to Indochinese health care clients. The University of Texas Health Science Center at Houston School of Nursing (UTHSC/H SN) proposes the following conditions for entering into sub-contract with the Indochinese Community Services, Inc. (ICS) to fulfill a grant from the Department of Human Resources.

The refugee nurse will need instruction and study in several areas of professional nursing in order to have adequate preparation to write NCLEX-RN. Students will enroll for a specially constructed curriculum designed to meet their particular needs spanning nine months (3 - 11 week quarters for a total of 33 weeks) April - December 1985 at the UTHSC/H SN.

Curriculum content will include the nursing process as applied in medical-surgical nursing, community nursing, psychiatric nursing, maternal-child health nursing, and assessment of both adult and child.

Class size will be limited to fifteen participants.

NOTE: This nine-month program was offered twice; in 1985 and again in 1986. Twenty-nine Vietnamese students completed the program. For further details, contact Gwen Sherwood, R.N., M.S.N., Assistant Professor and Director of Continuing Education. The University of Texas, Health Science Center at Houston, Texas Medical Center, 1100 Holcombe Blvd., Houston, TX 77030, 713-792-7800.

ATTACHMENT N: Social Service/Mental Health Programs

Harold Washington College (Formerly Loop College)
Department of Applied Sciences
30 East Lake Street
Chicago, Illinois 60601

Contact: Samie Dortch, M.A., A.C.S.W., Coordinator

Program Title: Social Service/Mental Health Programs

Harold Washington College's Social Service/Mental Health programs prepare students for entry-level positions in these helping professions, for transfer to a four-year college, or for career advancement for those already working in the social service area. Students may elect to earn a degree or a certificate, to enroll full-time or part-time, to attend during the day or the evening. The curriculum integrates the theory of Social Service/Mental Health practice with the student's own experiences and with a work-experience practicum. Students learn basic skills which can be used effectively in a variety of client situations: with individuals, groups, families or communities.

CAREER & EMPLOYMENT POSSIBILITIES

Harold Washington College program graduates have the necessary skills to work as paraprofessionals in public and private social welfare agencies, community mental health centers, day care facilities and community-sponsored social service organizations. Job titles vary: case work assistant, mental health technician, social work aide, etc. Responsibilities may include working with battered women or alcohol and substance abusers, counseling families, doing intake interviews,

recording psychosocial (background) histories of patients, and making referrals to other agencies. Salary and the range of responsibilities may depend on previous work or volunteer experience.

Positions at the professional level (requiring a bachelor's or master's degree) include school, employment or rehabilitation counselor; social worker; shelter director; volunteer service director; public health worker; community health director or welfare worker.

Degree & Certificate Programs

SOCIAL SERVICE AIDE, FAMILY WELFARE

Advanced Certificate (30 credit hours)*	Credits
Social Service 101 - Basic Concepts in Social Service	3
Social Service 201 - Principles of Social Work Practice	3
Social Service 212 - Introduction to Group Process	3
Social Service 215 - Social Problems & Social Action I	3
Social Service 228 - Principles of Family Welfare	3
Social Service 229 - Practicum in Family Welfare	6
Child Development 101 - Human Growth & Development I	3
Child Development 102 - Human Growth & Development II	3
Home Economics 107 - Child Care	3
	30

Associate in Applied Science (AAS) Degree (60 credit hours)*	Credits
Advanced Certificate requirements (see above)	30
plus	
General Education courses	30
	60

SOCIAL SERVICE Associate in Arts (AA) Degree (60 credit hours)

Basic education and liberal arts courses for students who intend to transfer to a four-year college or university. For additional information, contact the Program Coordinator.

MENTAL HEALTH ASSOCIATE

Advanced Certificate (32 credit hours)	Credits
Child Development 101 - Human Growth & Development I	3
Child Development 102 - Human Growth & Development II	3
Mental Health 228 - Principles of Mental Health Practice	3
Mental Health 229 - Practicum in Mental Health (2-credit seminar plus 400 hours in the field)	6
Psychology 201 - General Psychology	3
Psychology 213 - Abnormal Psychology	3
Social Service 101 - Basic Concepts in Social Service	3
Social Service 109 - Report Writing	2
Social Service 201 - Principles of Social Work Practice	3
Social Service 212 - Introduction to Group Process	3
	32

*In addition to the required courses, Social Service 109: Report Writing (2 credits) is strongly recommended as an elective course.

Associate in Applied Science (AAS) Degree (62 credit hours)	Credits
Advanced Certificate requirements (see above)	32
plus	
Biology 101 - General Course I	3
Biology 102 - General Course II	3
English 101 - Composition I	3
English 102 - Composition II	3
Home Economics 103 - Nutrition	3
Psychology 203 - Educational Psychology	3
Psychology 208 - Psychology of Exceptional Children OR Child Development 205 - Development of the Exceptional Child	3
Social Science 101 - General Course I	3
Social Science 102 - General Course II	3
Elective course	3
	62

RECOMMENDED AREAS OF SUPPORTING COURSEWORK

The Harold Washington College Social Service/Mental Health programs focus on a holistic (understanding the whole person) approach to working with people and helping them learn creative problem-solving approaches. With this in mind, students are urged to take elective courses in psychology, sociology, child development, anthropology, law enforcement and alcoholism/substance abuse to become familiar with various disciplines' approaches to the problems of individuals, groups, or society as a whole.

ATTACHMENT O: Hahnemann University Associate of Mental Health Program

Hahnemann University, School of Allied Health Professions
Broad and Vine
Philadelphia, Pennsylvania 19102-1192

Contact person: Joseph R. Casey, Associate Director
Mental Health Associate Degree Program
(215) 448-8121

and

Yang Sam, Executive Director
Southeast Asian Mutual Assistance Associations
Coalition, Inc.
4039 Walnut Street
Philadelphia, Pennsylvania 19104
(215) 823-5485

Program Title: Mental Health Associate Degree Program

Trainees: Bilingual refugees selected by their respective communities

The Hahnemann Mental Health Associate Degree program is designed to fill a personnel shortage in the mental health field by producing technically well-trained people who can complement mental health and human service agency staff in preventive programming and community outreach to high risk populations. The program focuses on inner city populations, i.e., culturally different and lower socioeconomic groups, as well as being centered on children and family issues. One of the goals of the program is to train people who will have practical skills and awareness of clinical realities, and who can appreciate community needs and understand the language of the community. The student is trained to be consumer oriented rather than entrenched in the medical "disease" model.

The two year program include courses, practicum assignments, supervised field experiences and mental health seminars. The

curriculum is designed to integrate a basic foundation in liberal arts subject areas with mental health related courses. There is a heavy emphasis on psychology and sociology, with courses in the practice and modalities of therapeutic and preventive intervention. Placements in mental health and human service settings are supervised by an interdisciplinary staff.

Students may complete an additional two years of academic and clinical work to obtain a B.S. degree.

The Southeast Asian Mutual Assistance Associations Coalition has recruited refugees to work as paraprofessionals in their Mental Health Project and has tied in to Hahnemann University for training in the AA program. The University has responsibility for assessment of English and general ability for success in the program. Candidates are sent to Saint Joseph's University for six weeks of intensive English training. The students are expected to spend twenty hours per week working at the Refugee Mental Health Program. Financial support for the trainees is provided by the University's provision of free tuition, and their employment at the Coalition's Mental Health Project.

References:

Brochure entitled, "Mental Health Technology Associate Degree Program." Hahnemann University. Philadelphia: School of Allied Health Professions.

Brochure entitled, "Mental Health Technology Program." Hahnemann University. Philadelphia: School of Allied Health Professions.

Burger SO: Work Plan and Policy and Planning Abstracts. Department of Public Welfare. Harrisburg: Office of Policy Planning and Evaluation.

Southeast Asian Mutual Assistance Coalition, Inc. (1986, October): The Organization of Southeast Asian Mental Health in Philadelphia. Refugee Consultation Conference. Philadelphia, Pennsylvania.

ATTACHMENT P: Adelphi Training Program for Emigres:

TRAINING PROGRAM IN HUMAN SERVICES COUNSELING FOR EMIGRES

Institute for Child Mental Health
Affiliated with Adelphi University
22 East 28th Street
New York, N.Y. 10016

Contact person: Katharine Schuchman, ACSW
Program Director
(212) 725-8611

The Training Program in Human Services Counseling for Emigres has been funded by the Refugee Entrant Assistance Program of the New York State Department of Social Services since 1978. It prepares eligible and qualified candidates for entry level human services employment.

In this on-the-job training program, adult refugees learn the basic theoretical and practical concepts of human services delivery, and how to combine this understanding with their respective linguistic, cultural and vocational skills. Upon completing the full-time, 20-week program, they are prepared to join the staffs of a variety of agencies serving culturally-diverse client populations.

Based upon traditional social work education principles, the 35-hour per week Training Program consists of 21 hours (3 days) of professionally-supervised field placement in a social agency and 14 hours (2 days) of classroom education in the areas of human growth and development, methods of helping people, history of the American Social welfare system, the integration of theory and practice, and English for the human services field. The more than 80 cooperating field placement

agencies include public schools, hospitals, resettlement agencies, refugee and entrant self-help organizations, a congressman's office, the N.Y.C. Police Department/New Immigrants Unit, the N.Y.C. Health Department, foster care and adoption agencies, and other service delivery organizations.

Between 1978 and 1986, the Training Program educated 321 refugees from Cuba, Haiti, Vietnam, Cambodia, Laos, Ethiopia, Afghanistan, Zaire, Poland, Rumania, and the U.S.S.R., for employment requiring multi-lingual, multi-cultural skills. Most of the training-related job placements are in resettlement agencies and programs where graduates work as bilingual case aides, escort workers, counselors, culturally-relevant translators, and in similar capacities. To date, 85% of program graduates are gainfully employed - 70% in training-related positions.

Two unique aspects of this program should be emphasized. First, on-going counseling is provided by experienced professionals (MSW's) during the training, both individually and in classroom seminars and small group sessions.

Lastly, all training cycles reflect the multi-cultural nature of the refugee/entrant population. Thus, students graduate with an ability to understand and function within the American pluralistic society.

ADMISSION TO THE PROGRAM

The endeavor to locate and screen suitable candidates for this Training Program is an intensive process involving the entire staff. The final

goal of the procedure is the choice of a class composed of members of various refugee/entrant groups whose command of English is good and whose intelligence, academic background, interpersonal skills, and motivation for social service are strong. Generally, the demand for training far exceeds the number of spaces available in a given cycle, and qualified candidates must be turned away and encouraged to re-apply.

REQUIREMENTS

The prospective trainee must meet certain criteria as required by the funding source - the N.Y.S. Department of Social Services - as well as educational and motivational criteria established by the Training Program. These include the following categories:

a. IMMIGRATION STATUS. The applicant must provide evidence of the appropriate visa (refugee/entrant or the legal equivalent) and social security numbers for him/herself, family, and household members.

b. INCOME ELIGIBILITY. The funding source has established fixed income levels which must be met and for which official proof must be provided.

c. EDUCATIONAL BACKGROUND. Trainees are required to have as a minimum requirement the equivalent of an

American secondary school education. Whenever possible, the program seeks to enroll individuals with preparation beyond high school. Documentation of education is requested; however, the program staff recognizes that many refugees and entrants face exceptional barriers in securing credentials, and allowance will be made for the lack thereof. G.E.D. is acceptable.

d. ENGLISH PROFICIENCY. The candidate must achieve a satisfactory score on a standard written test of English. In addition, the applicant's oral communication skills are assessed in the interview.

THE ELIGIBILITY INTERVIEW

a. INITIAL INTERVIEW. During this initial interview, the candidate's documents are reviewed, application forms are completed, and the interviewer makes a preliminary assessment as to the applicant's suitability for the program. She seeks to verify and compile technical information and to ascertain the level of spoken ability in English. Upon completion of the interview, she administers a one-hour English test. Finally, the applicant completes a questionnaire designed to elicit levels of interest in, and motivation for, the human

services profession. If the applicant passes the English test, a second interview is scheduled.

b. SECOND INTERVIEW. The second interview is conducted by a certified staff social worker who completes a specially designed evaluation form focusing primarily on personality assessment. She attempts to discover the applicant's level of self-awareness, intelligence, interpersonal skills, and degree of motivation and interest in the human services.

c. SELECTION. Selection is completed by the entire program staff with the final decision guided by a variety of factors, including the availability of field placement sites and professional supervision, and future employment potential related to each refugee/entrant group as well as the technical and personality assessment previously mentioned. Candidates are notified by mail of the committee's action.

TRAINING MODEL

The Training Program consists of 20 weeks of full-time training based on the traditional social work education format. This includes 3 days per week (21 hours) of professionally-supervised field work in a

social service agency and 2 days per week (14 hours) of related classroom instruction.

ACADEMIC INSTRUCTION. Classroom instruction includes intensive ESL instruction for human service workers and courses familiarizing students with the American social welfare system and the methods and skills of the helping process.

DESCRIPTION OF COURSES

ENGLISH FOR HUMAN SERVICE WORKERS

Participants receive instruction in vocabulary utilized in the profession of human services and also have the opportunity to improve their language skills in all areas of written and oral communication. Recording and writing of reports and letters are given special attention.

INTRODUCTION TO HUMAN SERVICES: UNDERSTANDING PEOPLE AND THE HELPING PROCESS; HUMAN GROWTH AND DEVELOPMENT

These classes provide the refugee student with a basic introduction to the American human services and social work field and the skills, knowledge, techniques, and concepts needed to successfully enter the American social agency as a helping professional. Students study such concepts as values, roles for human service workers, self-awareness, the helping relationship, helping skills, and basic human

needs. Models of behavior and development and the role of the family are also covered.

SEMINAR IN SKILLS IN HUMAN SERVICES

In this course, students are helped to integrate theoretical material with practical experience gained in field work as well as with personal feeling evoked by previous life experience and daily client interaction in the agency setting. The concepts introduced related to the study of the client's situation, personality, and environment. Students become familiar with the concept of social diagnosis and to the process of planning remedial intervention. Case material is utilized. An attempt is made to help the trainees to use social work methods of intervention in working with individuals, groups, and communities. The basic philosophies, concepts, principals, and values of social work are covered.

INTRODUCTION TO SOCIAL WELFARE SERVICES IN AMERICA

The course acquaints the trainees with the political, economic, and social structures of this country and its pluralistic society, its social problems and the institutions of social services. It helps students to understand the various programs which make up the social welfare system and seeks to explain and discuss the role and differences between the public and voluntary social service agencies. In the process of covering this material, students obtain insight as to how an agency functions and become aware of the difference between

goals and reality. The course also aims to foster an appreciation of some of the basic underlying American cultural values as contrasted with those of refugee cultures and endeavors to encourage students to adjust to a new pattern of relating to an American instructor in a classroom setting.

FIELD EXPERIENCE

Students report to their fieldwork agencies three days a week for a total of 21 hours per week for a period of twenty weeks.

The purpose of the fieldwork placement is to familiarize the trainees with the structures and functions of social work agencies, their day-to-day operations, procedures and guiding principles as well as social work values as evidenced in practice. Trainees are expected to integrate and apply knowledge, theory and understanding acquired in the classroom. They are also expected to assume responsibility for productive execution of tasks in the social welfare field on the beginners level. It is hoped that they will have the possibility to observe and identify with helping persons in their various professional roles. Finally, opportunities are provided for students to assess their own interest, motivation and capacity for a career in the field of human services. In order to fulfill these expectations, fully qualified professional supervision is provided by the cooperating agencies.

COUNSELING AND ADVISEMENT

The Training Program is staffed by professional, certified social workers who are available to students for personal, academic, and employment counseling and advisement.

INSTRUCTORS MEETINGS

Meetings of the instructors are held on a regular basis throughout the course of each cycle. At these sessions, an interchange of ideas relating to methods and content of instruction takes place.

PROFESSIONAL CONSULTATIONS

Outside expertise is highly valued by the program staff, and frequent lectures and workshops led by prominent educators and authorities are scheduled throughout the course of the program.

EDUCATIONAL RESOURCES

The Training Program maintains a circulation library which includes social work texts and copies of literature in various forms related to refugee concerns. It also subscribes to publications which provide both technical and clinical information regarding refugee resettlement. The Adelphi University circulating and reference library is also available.

Pertinent material covering all ethnic groups is available for use by instructors and their students. Field trips are conducted to various locations to help trainees obtain an overall view of the American environment. Lastly, audiovisual material is also available, and the materials and resources described above are continually enriched by the addition of recently issued information.

ATTENDANCE AND PUNCTUALITY

Students are expected to report regularly to both class and field placements. It is the student's responsibility to notify both the classroom instructors and the agency supervisor of absence or lateness. Excessive absence will be reflected in the student's final grade. Students must complete the total number of 420 field work hours. Students will follow agency schedules regarding holidays.

ACADEMIC CREDIT

Upon completion of all program requirements, students will receive a Certificate of Completion, as well as 10 undergraduate academic credits from the Adelphi University School of Social Work.

FINANCIAL ASSISTANCE

An allowance for transportation and incidental costs related to training is available and payable bimonthly. In addition, minimal financial aid is possible for students demonstrating great need.

Written application with documentation will be reviewed by the Financial Aid Committee.

PLACEMENT IN TRAINING-RELATED EMPLOYMENT

The program staff assumes the responsibility for active intervention on behalf of each trainee in searching for training-related employment both during the educational cycle and post-graduation.

THE EMPLOYMENT SEARCH

Various methods are implemented by the social worker, generally the student's advisor, to locate an appropriate position for each student. These include contacts with field agencies (past and present), supervisors, former students, and other professional contacts, formal and informal.

Throughout this process, the trainee maintains ongoing communication with the social worker, who acts as mentor. The advisor also helps the trainee to undertake his/her own employment investigation, keeping her up-to-date on relevant developments so that she can coordinate the entire process efficiently.

Although placement concludes the daily communication between the trainee and the social worker, the individual is welcome to return for future assistance should the need arise, and is urged to serve as a resource by contacting the program staff when openings occur in his agency.

Trainees have found employment in the following capacities and work settings:

Case Aides/Interpreters in Refugee resettlement agencies, hospitals and clinics, foster care/family health centers

Therapeutic Aides/Interpreters in Geriatric facilities

Educational Assistants/Interpreters in N.Y.C. Board of Education, N.Y.C. Police Department/New Immigrants Unit, N.Y.C. Health Department

Free Lance Translators with private agencies, N.Y.C. Board of Education

ATTACHMENT Q: Course Outline, Department of Family Practice, University of Minnesota Medical School

CULTURAL ASPECTS OF DELIVERING HEALTH CARE TO HMONG PATIENTS
INSTRUCTIONAL PLANNING
KATHIE CULHANE-PERA, M.D.
SEPTEMBER 18, 1987

I. THE PROBLEM

A. THE SOCIAL PROBLEM

There are conflicts between the Family Practice residents and the Hmong patients due to cultural differences about the appropriateness of health care such that residents are frustrated and Hmong patients are not receiving optimal care.

B. THE EDUCATIONAL PROBLEM

The residents, from their ethnocentric and medicocentric viewpoint, do not know about Hmong cultural viewpoints of health and illness, and do not know how to deal with cultural differences.

II. BROAD GOALS

Residents will become less ethnocentric and medicocentric and will effectively deal with cultural differences so that they can administer culturally sensitive health care and decrease their own frustration.

III. BROAD OBJECTIVES

Residents will acquire knowledge about Hmong culture and will acquire a more ethnorelative and medicorelative attitude so that in a clinical setting they will be able to render culturally sensitive health care. The evaluation and the course design will follow Bennett's Developmental Model of

Cultural Sensitivity.

IV. OVERALL FORMAT

A series of eleven hour-long conferences, ten during the noon hour conferences and one during a Friday morning staff conference.

V. CURRICULUM MODULES WITH CORRESPONDING ENABLING OBJECTIVES; COGNITIVE, ATTITUDINAL, AND BEHAVIORAL

#1. INTRODUCTION TO "CULTURAL ASPECTS OF DELIVERING HEALTH CARE TO HMONG PATIENTS"

A. Goals, strategies, and time:

1. Engage their interest in the course by leading a group discussion on the difficulties of delivering health care to the Hmong people. Acknowledge frustration. Group discussion. 20 minutes.

2. Explain goals of the course, attaching to theory; knowledge and attitudes needed to reduce frustration and improve health care. Course follows Bennett's Developmental Model of Sensitivity. Course syllabus with dates, topics, and corresponding stages. Mini-lecture. 20 minutes.

3. Start process by dealing with perceptions. Group exercise. 20

minutes.

B. Objectives

1. Know the course's goals and direction.
   a. List three cognitive areas to be dealt with in the course.
   b. List three attitudinal areas to be addressed in the course.
   c. Explain which attitude orientation they would prefer to have.
2. Show awareness of the importance of learning about cultural differences.
   a. Choose to answer the questionnaire.
   b. Choose to attend the presentation.
   c. Choose to listen to presenter.
3. Show interest in learning about the importance of culture.
   a. Participate in discussion on difficulties in dealing with Hmong patients.
   b. Participate in the exercise on role of perception in categorizing people.
   c. Express enthusiasm in course objectives.

C. Assignment: Increase awareness of your attitudes towards Hmong patients by self-monitoring or by discussing with others.

D. Suggested readings:

Galazka and Eckert: "Clinically Applied Anthropology: Concepts for the Family Physician" J. FP, 22(2): 159-165, 1986.

#2. ASPECTS OF TRADITIONAL HMONG CULTURE

Bennett's Stage: Minimization. Recognition of similarities between Hmong and ourselves, between their ways of dealing with life and life transitions, and ours; recognition of "good" of other's culture and of one's own culture.

A. Goals, strategies, and time

1. Increase awareness that differences are really trivial, that "they are just like us" via the film "Great Branches/New Roots" which depicts Hmong kinship and aspects of traditional Hmong culture as they deal with life's transitions and as they adjust to this country and culture. 50 minutes.

2. Encourage acknowledgement of similarities in small group discussion. 20 minutes.

B. Objectives

1. Know aspects of traditional family

structure.

a. Define the clan structure.

b. Describe the importance of children to clan.

c. Explain duties and benefits of clan membership.

d. Describe concern about impact adjustment to this culture on clan strength.

2. Acknowledge similarities between Hmong people and self.

a. Describe similarities in non-verbal emotional expressions.

b. Describe relationship between family members which are like one's own.

c. Describe similar life crises which Hmong families and their families have dealt with (i.e., birth, death, courtship).

C. Assignments

In the next two weeks, while seeing Hmong patients, pay attention to the similarities between them and yourself, between their concern for their sick family members and your concern for your own, etc.

D. Reading

Dunnigan, T: "Segmentary Kinship in an Urban Society: The Hmong of St. Paul/Minneapolis" Anthropological Quarterly 55(3): 126-134. July, 1987.

#3. CROSS-CULTURAL COMMUNICATION AND INTERPRETATION

Bennett's theory: Acceptance, behavioral differences

A. Goals, strategies, and time:

1. Stress similarities and differences in non-verbal communication. Mini-lecture with presentation, dramatizing points. 10 minutes.
2. Address difficulties in verbal communication. Mini-lecture on Hmong language with lesson introductory phrases. Yer and Fue's input. 20 minutes.
3. Define different modes of talking through an interpreter: translation, interpretation, cultural brokerage. Mini-lecture followed by small group discussion of pros and cons of each mode. Yer and Fue in each group. 20 minutes.
4. Describe stress of the medical interpreter, caught between two worlds.

B. Objectives

1. Understand aspects of cross-cultural non-

verbal communication.

a. Describe the common element between all cultures.

b. Describe the impact of culture on emotional expression.

c. Describe the impact of Hmong culture on two aspects of non-verbal communication.

2. Understand aspects of Hmong language.

a. Describe limitations to direct translation.

b. Say hello and thank you in Hmong language.

c. Describe impact of learning Hmong phrases on doctor-patient relationship.

3. Understand aspects of communicating with an interpreter.

a. Define 3 roles of translator, interpreter, and cultural broker.

b. Describe a circumstance for all three roles.

c. Describe cultural milieu for Hmong interpreter when dealing with Hmong patients.

4. Accept cultural influence on verbal and

non-verbal communication.

C. Suggested Assignment

This week:

1. Pay attention to non-verbal communication cues, and then discuss them with Yer and Fue to judge "accuracy."
2. Apply different interpreter modes with Yer and Fue.
3. Practice Hmong phrases.

D. Suggested Readings:

Kaufert and Koolage: "Role Conflict Among 'Cultural Brokers': The Experience of Native Canadian Medical Interpreters." Social Science in Medicine 18(3): 283-286, 1984.

Holtan and Egli: "Working with Refugee Bilingual Health Workers in the Health Care Setting." Unpublished, 1987.

#4. CAMBODIAN (KHMER) TRADITIONAL HEALTH CONCEPTS

Bennett's Stage: Acceptance, behavior and value differences (and even empathy).

A. Goals, strategies, and time.

1. Present an example of Southeast Asian traditional health concepts and health care practices by viewing videotape, "House of the Spirits" on Khmer healing practices, in Kampuchea and in U.S. 50

minutes.

B. Objectives

1. Know range of Khmer traditional health care concepts.
   a. Describe different types of disease etiologies.
   b. List different types of healers.
   c. List different types of treatments.
2. Understand various treatment options available to Khmer refugees in U.S.
   a. Describe the pluralistic health care environment for the Khmer refugee.
   b. Describe two difficulties Khmer refugees may have when dealing with the American health care system.
3. Accept culture's impact on health care concepts.
   a. Acknowledge culturally appropriate manners of defining disease etiology.
   b. Acknowledge culturally appropriate healers and treatments.

4. Appreciates the difficulties of refugee adjustment.

   a. Empathizes with the difficulty of losing one's country and culture.

   b. Empathizes with the difficulty of adjusting to this country.

C. Assignment

While watching the videotape, list the various types of etiologies, healers and treatments.

#5. HMONG TRADITIONAL HEALTH CONCEPTS

Bennett's Stage: Acceptance, behavior and value differences.

A. Goals, strategies, and time.

1. Elicit the various types of etiologies, healers, and treatments for the Khmer as presented in the videotape the day before. Large group. 5 minutes.

2. Using that framework, compare and contrast the various Hmong disease etiologies, healers, and treatments. Mini-lecture. 15 minutes.

3. Yer to explain home remedies such as herbs, cupping, coining, and massage. Mini-lecture. 15 minutes.

4. Fue to explain KAWV KOOB. Mini-lecture. 15 minutes.

B. Objectives

1. Know Hmong traditional healing practices.
   a. List different types of healers.
   b. List different types of treatments.
2. Understand the different etiologies and values behind the different practices.
   a. Explain the different disease etiologies.
   b. Compare their etiologies with western medical etiologies.
3. Understand the various treatment options available to Hmong refugees in U.S.
   a. Describe the pluralistic health care environment for the Hmong refugees.
   b. Describe the difficulties Hmong refugees may have when dealing with the American health care system.
4. Accept traditional Southeast Asian healing practices and values.
   a. Describe the differences in respectful words and tones.
   b. Describe the practices without being pejorative.

c. Describe the value of balance and imbalance in health and illness without being pejorative.

5. Empathize with the Hmong refugees in this pluralistic system.

C. Assignment: Ask Hmong patients this week about their traditional practices. As they may be concerned about telling you, a physician, explain why you are asking in a non-threatening manner. Be aware of your own reactions towards their continuing or not continuing their traditional practices. Consider asking patients if you can attend a healing ceremony, HU PLIG or UA NEEG, or a baby's naming ceremony, KHI TES.

D. Readings:

Holtan, N: Sudden Unexpected Nocturnal Death Syndrome Final Report, St. Paul Foundation, November, 1984, pp. 30-43.

Thao, Xoua: Hmong Perception of Illness and Traditional Ways of Healing, from Hendricks, ed.: The Hmong in Transition, New York, Center for Migration Studies, 1985, pp. 365-378.

#6. HMONG ANIMISM AND SHAMANISM

Bennett's Stage: Acceptance of value differences.

A. Goals, strategies, and time:

1. Engage their interest in learning about traditional healing practices. Large group discussion. 5-10 minutes.
2. Explain Hmong traditional religion, animism. Lecture. 15 minutes.
3. Explain Hmong spiritual healer, the TXIV NEEB. Lecture. 15 minutes.
4. Expose them to a shaman ceremony, to a different mode of healing via viewing parts of Lemoine's videotape. 15 minutes.

B. Objectives:

1. Understand aspects of traditional animism.
   a. Describe the three major souls in the body.
   b. Describe what happens to these souls at death.
   c. Describe the spiritual etiology in illness.
2. Understand aspects of shamanism.
   a. Describe the elements of healing in shaman ceremonies/ rituals.
   b. State the goals of a shaman healing ceremony.
3. Understand the impact of the changing

environment on shaman procedures.

a. Describe the changes of the shaman's activities.

b. Discuss the influence of Christianity on the beliefs of the family.

c. Discuss the strength of traditional practices in adjusting to a new country.

4. Accept the value differences between shamanistic healing and western biomedical curing.

a. Acknowledge the importance of spirituality of Hmong concepts of health and illness.

b. Acknowledge the impact of cultural beliefs on form of healing, for both Hmong patients and American physicians.

C. Assignment: Ask Hmong patients this week about their traditional practices. As they may be concerned about telling you, a physician, explain why you are asking in a non-threatening manner. Be aware of your own reactions towards their continuing or not continuing their traditional practices. Consider asking patients if you can

attend a healing ceremony, HU PLIG or UA NEEG, or a baby's naming ceremony, KHI TES.

D. Readings:

Hammond, R: Tradition Complicates Hmong Choice, St. Paul Sunday Pioneer Press, 9/16/84.

Lemoine, J: Shamanism in the Context of Hmong Resettlement," in: The Hmong in Transition, ed. Hendricks, Center for Migration Studies, 1986.

In addition, the previous readings from "Hmong Traditional Healing Practices" are appropriate.

#7. THE HMONG REFUGEE EXPERIENCE

Bennett's Stage: Adaptation, empathy.

A. Goals, strategies, and time:

1. Increase awareness of the hardships in being a refugee: losses of traditional life and adjustment to this country via listening to Hmong people describe their refugee experience in a small group setting. Have refugees tell their own story, including elements of loss and grief, difficulties in adjusting, as well as instances of suspicion and distrust of others with whom they came in contact. 50 minutes. (Also, may reflect on A-V materials: "Great Branches/New Roots" and "Between Two Worlds.")

B. Objectives: After listening to mini-lecture and talking with Hmong refugees on a one-to-one basis, the resident will:

1. Know the historical and geographical factors of Hmong refugee flight.
   a. Name countries and major places of Hmong refugee flight.
   b. Briefly state the historic background leading to Hmong refugee flight.
   c. Briefly describe America's position towards Hmong refugees.
2. Understand adjustment barriers which Hmong refugees face.
   a. Describe impact on family of choosing to leave Laos and Thailand.
   b. Describe impact on social roles of adjusting to America.
   c. Discuss cultural issues in adjusting to America.
   d. Describe one person's issues in adjusting to America.
3. Empathize with refugee experience.
   a. Describe one's own emotional affinity for the losses

suffered by Hmong refugees.

b. Describe one's own emotional reaction to the hurdles and barriers in adjusting to America.

C. Assignment: In the next week, ask patients about some aspect of their refugee experience and consider the influence of these losses and adjustments on their mental and physical health.

D. Readings:

United States Committee for Refugees, an Issue Paper: Refugees from Laos: In Harm's Way," American Council for Nationalities Service, July, 1986.

Stein, BN: The Experience of Being a Refugee: Insights from the Research Literature. In Williams and Westermeyer (eds.): Refugee Mental Health in Resettlement Countries. Hemisphere Publishing Corporation, Washington, 1986.

#8. REFUGEE MENTAL HEALTH: SOMATIZATION VERSUS SOMATIC DISORDERS

A. Goals, strategies, and time:

1. Alert them to the necessity of considering psychiatric and medical diagnoses concurrently; how to differentiate between somatic and psychosomatic disorders.

2. Expose them to cross-cultural differences

and similarities in dealing with mental health.

3. Familiarize them with one knowledgeable psychiatrist.

   Strategy: Lecture by Dr. J. Westermeyer to residents and attending staff during Friday Morning Staff Conference. 60 minutes.

B. Objectives:

1. Understand difference between somatic and psychosomatic presentations.

   a. Characterize typical presentation of somatic disorders.

   b. Characterize typical presentation of psychosomatic disorders.

   c. Describe the interaction between somatic and psychosomatic disorders.

2. Understand aspects of refugee experience which impact on mental health.

   a. Describe cultural aspects which influence expression of mental health issues as physical complaints.

   b. Describe cultural aspects of

conflicting presentations of psychosomatic disorders.

#9. HMONG PEOPLE'S REACTIONS TO SURGERY AND OBSTETRICS

Bennett's Model: Adaptation: pluralism.

A. Goals, strategies, and timing:

1. Apply traditional concepts of health and illness to two hospital arenas with potential for conflict; surgery and obstetrics.
2. Illustrate desired pluralistic orientation by respectfully describing the two different cultural views in the two cases, one surgical and the other obstetrical.
3. Mini-lectures with large group discussion.
4. 25 minutes for surgery and 25 minutes for obstetrics.

B. Objectives:

1. Understand impact of traditional culture on concerns about surgery.
   a. Describe influence of souls and reincarnation on decision to have an operation.
   b. Describe influence of social stigma and role performance on

decision to have an operation.

c. Describe influence of impaired physical function on decision to have an operation.

d. Describe influence of perceived cause and appropriate treatment on decision to have an operation.

2. Understand impact of general refugee experience on reactions to foreign healing practices such as operations.

a. Describe Hmong people's suspicion about physicians' motives.

b. Describe Hmong people's need to maintain control and to make decisions.

3. Understand aspects of traditional Hmong culture which impact on obstetrical care.

a. Explain traditional birth practices.

b. Explain traditional post-partum practices.

c. Describe the persistence of traditional practices in this country.

4. Recognize their emotional responses to

Hmong people's acceptance or rejection of their proposed biomedical treatment plans.

a. Describe feelings towards Hmong patient and family in case when the recommended biomedical care plan was refused.

5. Appreciate the importance of pluralism.

C. Assignment: In the next week, be aware of the different pervasive cultural views of whatever clinical problem area you are faced with; notice how you look at the situation differently than the Hmong patient and family do. Put yourself in their place, and alternate between considering their view and considering your own.

D. Suggested readings:

Nelson, CC and Hewitt M: An Indochinese Refugee Population in a Nurse-Midwife Service. J. of Nurse-Midwifery, 23(5): 9, September/October, 1983.

"Questions and Answers: Cultural Beliefs and Surgical Procedures." JAMA 255(23): 3301, June 20, 1986.

#10. REFUGEE MENTAL HEALTH AND COLLABORATING WITH TRADITIONAL HEALERS

Bennett's Stage: Pluralism.

A. Goals, strategies, and time.

1. Emphasize impact of refugee experience on mental and physical health and subsequent need to evaluate psychological component concurrently with an appropriate work up of somatic complaints. Mini-lecture. 10 minutes.
2. Present overview of different psychological disorders and treatments with referral sources. Mini-lecture. 10 minutes.
3. Introduce them to a Hmong shaman in order to emphasize the reality of collaborating (indirectly or directly) with traditional healers. Mini-lecture by Hmong shaman with questions. 40 minutes.

B. Objectives:

C. Assignment: In the next week, concentrate on simultaneously considering the somatic and the psychological nature of symptoms. Consider patients you have already seen who may have been somaticizing, and decide what further physical workup to do, and decide what further psychological workup and referral to do, including traditional healers.

D. Suggested readings:

Bliatout, B: Guidelines for Mental Health Professionals to Help Clients Seek Traditional

Healing Treatment. In: Hendricks, Downing and Deinard (eds.): The Hmong in Transition, Center for Migration Studies, 1986.

DeLay, P and Faust S: Depression in Southeast Asian Refugees. American Family Physician: 179, October, 1987.

Holtan, N: Mental Health Issues for Southeast Asians in the United States. Chapter 5, SUNDS Final Report, St. Paul, November, 1984.

#11. CONCLUSION: NEGOTIATING CONFLICTS IN THE HEALTH CARE SETTING

Bennett's Stage: Adaptation: Pluralism and Integration: Contextual evaluation. Reflecting different viewpoints onto situation. When making decisions, understanding and evaluating options from both cultural frameworks.

A. Goals, strategies, and time:

1. Case presentation which depicts a conflict which can be viewed from both sides. Demonstrating CONTEXTUAL EVALUATION. Discuss case in large group, encouraging them to apply the information learned so far. 20 minutes.
2. Present concepts of negotiation, the LEARN model, while reviewing the culturally appropriate information presented in the course. Mini-lecture, 30 minutes.

3. Present theoretical concepts of medical anthropology. Mini-lecture. 10 minutes.

4. Explain evaluation process. 2 minutes.

B. Objectives:

1. Know about cross-cultural health education materials in the clinic.

   a. List available written and media resources.

   b. Describe how to operate media materials.

   c. Describe situations when education materials are useful.

2. Understand principles of negotiation.

   a. Explain the goal of doctor-patient negotiation.

   b. Describe the information needed to affect negotiation.

   c. Explain the LEARN model.

C. Assignment: Negotiate some aspect of dealing with Hmong patients: performing exam, doing diagnostic procedure, deciding on treatment option.

D. Suggested readings:

Berlin, EA and Fowkes, WC: A Teaching Framework for Cross-Cultural Health Care: Application in Family Practice. Western Journal of Medicine, 139(6): 835-840, December, 1983.

Kleinman, A: Culture, Illness, and Care: Clinical

Lessons from Anthropologic and Cross-Cultural Research. Annals of Internal Medicine 88:251-258, 1978.

Muecke, M: In Search of Healers--Southeast Asian Refugees in the American Health Care System. Western Journal of Medicine 139(6): 835-840, December, 1983.

IN ADDITION, THERE WILL BE GENERAL TERMINAL OBJECTIVES OF APPLYING KNOWLEDGE AND PRINCIPLES LEARNED:

1. Apply principles of cross-cultural medicine.
   a. Demonstrate the identification of relevant cultural components in a clinical setting.
   b. Demonstrate the identification of a person's explanatory model of their illness and their desired treatment.
   c. Utilize these factors in taking a history, in performing a physical examination, and in assessing the complaint.
2. Apply principles of negotiation.
   a. Negotiate culturally sensitive treatment plans utilizing the LEARN model.
   b. Discover the advantages of negotiating with patients.
   c. Modulate their barriers to negotiation.

3. Recognize cultural factors which are potential sources of conflict.
   a. Identify the impact of different explanatory models on doctor-patient communication.
   b. Identify how Hmong values of harmony and authority impact on doctor-patient communication.
   c. Identify aspects of traditional healing which may need to be addressed before certain aspects of biomedicine are agreed to.
4. Integrate principles to a home care setting.
   a. Describe the cultural material gathered in a home visit which was not gathered in the clinic setting.
   b. Apply the material to the assessment and treatment plan.
5. Utilize the health education materials in a culturally sensitve manner.

AND INTEGRATING THE CONCEPTS LEARNED:

1. Integrate principles of cross-cultural medicine to other, non-Hmong, patients.
   a. Relate principles of negotiation to other clinic patients.
   b. Relate principles of refugee mental health to other refugee patients.

2. Integrate the impact of the general refugee experience on mental and physical health.
   a. Pursue psychological and somatic components of physical complaints.
   b. Inquire about patients' flights from Southeast Asia.
   c. Inquire about adjustment to this country.
   d. Make appropriate mental health referrals.
3. Recognize a need to balance physician's viewpoint with patient's viewpoint.
   a. Compare and contrast the different desired treatment option.
   b. Defend patient's right to decide own treatment plan.
   c. Alter own goals, from treatment outcome to discussion process.
   d. Acknowledge American conflict regarding parental versus state's rights in children's welfare.

AS WELL AS OVERALL ATTITUDES OBJECTIVES:

1. Recognize the role of cultural differences in health care choices.
2. Appreciate different value systems and world views with regard to health care.
3. Recognize biomedicine's explanatory model as a cultural construct.
4. Demonstrate ethnorelative attitude in working with

Hmong patients.

5. Demonstrate ethnorelative attitude in working with all patients.

ATTACHMENT R: Concept Paper - Clinical Training for Refugee Specific Primary Care

Note: This concept paper, by Richard Mollica, M.D., Director, Indochinese Psychiatry Center, Brighton-Marine Public Health Center, Boston, and Janice L. Thompson, Ph.D., Human Services Development Institute, University of Southern Maine, Portland, is excerpted from THE INTEGRATION OF REFUGEE MENTAL HEALTH CARE IN EXISTING SYSTEMS, Final Report, by Janice L. Thompson and Alice Lieberman, Maine State Department of Human Services, November, 1986.

CONCEPT PAPER

CLINICAL TRAINING FOR REFUGEE-SPECIFIC PRIMARY CARE

Concept/Focus: This alternative approach to refugee mental health would prepare primary care providers to screen, diagnose, and treat refugee-specific mental health problems. Primary care providers are those health care professionals who function as the first point of contact for patients within the health care system. Here the focus is on preparing primary care physicians (e.g., family practice, internal medicine, pediatrics) and nurses (e.g., nurse practitioners, community health nurses) to screen, diagnose and treat both the biomedical and psychosocial dimensions of refugee health problems. The concept then is to integrate refugee mental health care into the primary care that refugees are already receiving in existing mainstream institutions.

Need/Problem: Findings from a previously funded statewide mental health needs assessment in Maine indicate that, in the opinion of key informants, refugees are experiencing significant psychosocial problems related to their previous experience as victims of war and trauma and their ongoing experiences of adjustment in this society. These problems include family violence, substance abuse, depression,

isolation of the elderly and institutional racism. There is consensus among key informants that, although these problems are serious and in many cases severe, there are no adequate resources to which refugees may be referred for appropriate, effective treatment. There is also consensus among key informants that the separation of mental health from health care in general is inappropriate for this population. Psychosocial and psychiatric problems are viewed as being best treated in an integrated, holistic approach to refugee health. Since controversy exists over the development of specialized mental health services for refugees, since recent policy initiatives suggest a preference for mainstreaming refugee health care, and since a strictly psychiatric approach to refugee mental health seems inappropriate, we suggest that primary care providers working in existing institutions might be trained to provide comprehensive, holistic refugee health care.

Approach: The suggested approach to this problem would be to train primary care providers on site in institutions that serve as a major source of access to primary care for the refugee population. We envision an initial concentrated training period, possibly two or three days a week, for one or two weeks, on site in clinic settings where refugees are seen. The focus here would be to train primary care providers to use developed protocols to screen, diagnose and treat refugees for specific mental health problems as part of the total plan of care for refugee patients. After this initial phase of on site clinical training, a second scheduled on-site visit would follow some months later, to review participants' clinical experience with

refugees, giving them the opportunity to evaluate their clinical practice with refugees and consult trainers for additional learning. There probably would be a need to develop mechanisms for interim consultation between those two site visits, for example, telephone consultation with trainers or local refugee medical rounds to review specific cases.

Training Participants: Those who would be targeted for this training include physicians and residents in the following medical specialities: family practice, pediatrics, obstetrics-gynecology, and internal medicine. Providers from psychiatry would also be invited to participate as a way to build institutional expertise when referral is needed. Due to the composition of the medical community in Maine, we would also include osteopathic physicians as participants in the training. Additionally, we would include nurses in this training, since many refugees are seen on an ongoing basis by nurses in various extended roles. These would include adult, family, pediatric, and psychiatric nurse practitioners or clinical nurse specialists as well as community health nurses. Psychiatric social workers who function in clinical settings as mental health specialists would also be invited to participate.

Location: We envision a concentrated area of training with providers who work with the refugee population in the greater Portland, Maine, area. This probably would be a group of not more than fifteen people who have been identified through the mental health needs assessment project. Those involved in training would include providers

in the regional medical center and two other community hospitals where refugees are most frequently seen. This geographical area is an important location to begin the training since the largest concentration of refugees in Maine reside in the greater Portland area. We feel that this kind of clinical training for a small group of primary care providers would prepare a small but critical mass of providers who could then function as trainers themselves for providers in other areas of the state.

Trainers: The concept of clinical training for primary care providers has developed from collaborative work between Richard Mollica and the IPC staff in Boston, and Janice Thompson, a faculty member from the School of Nursing and the University of Southern Maine. Dr. Mollica and the IPC staff have expressed a willingness to work with Dr. Thompson on curriculum development and on-site clinical training in Maine. Other resources include the Division of Continuing Education for Health Professions from the University of Southern Maine. This is a vehicle for awarding continuing education credit to health care professionals who might participate in training.

ATTACHMENT S: Concept Paper - Language Planning in Refugee Mental Health

LANGUAGE PLANNING FOR INTERPRETING AND TRANSLATING SERVICES: A FUNDAMENTAL CONTENT AREA FOR INCLUSION IN MODELS OF PROFESSIONAL AND PARAPROFESSIONAL TRAINING IN REFUGEE MENTAL HEALTH

Laurel Benhamida

The major goal of including content about language planning in mental health research and practice in professional and paraprofessional training programs is to produce future generations of mental health professionals who will consider good quality interpreting and translating services essential to successful, cost-effective, and responsible patient/client care. These future generations will then be prepared to make the planning, budgetary, and day-to-day patient/client care decisions necessary to ensure quality linguistic services for refugees and immigrants. When they work in a mental health setting where it is possible that non- or limited English speaking patients will need to be served, their training will have provided them with the knowledge to plan for the language needs of these patients. This will be true whether the setting is a community agency, a university teaching hospital, or a state mental health institution. The more highly paid and hence influential professionals and those who will be administrators will be educated to hold the position that it is a matter of professional responsibility that care for refugee and other non-English speaking patients includes planned, quality interpreting services when services provided by bilingual professionals--not just paraprofessionals-- are unavailable. Since we can anticipate that

Spanish will be the only language where sufficient numbers of bilingual medical and mental health professionals will be available, and then only in a few states and urban areas, the only remaining alternative to bridge the language barrier will be interpreting and translating.

This goal will take at least a generation, probably more, to achieve but it is achievable. The deaf community in the U.S. has accomplished many of the above goals for its members. Linguistic research, both theoretical and sociolinguistic, has shown the Deaf to be a minority group with a language and culture of their own. The disability-based model of perceiving the Deaf in the United Sates has been replaced by this model. Their language is American Sign Language, which has a syntax, morphology, and phonology, just as spoken languages do. American Sign Language can be acquired naturally by children just as spoken languages are. Deaf people have their own values, norms of behavior, humor, prejudices, and world view just as other cultural groups do. English is a second language for Deaf people in the United States. Written communication in English with them is not necessarily any more successful with them than with any other non-native English speaker: success depends on their English competency which varies from individual to individual. Past generations of medical and mental health professionals did not deal with the language barriers to the Deaf patient through qualified interpreters: indeed few if any were available. Today the situation has changed dramatically and for the better. Qualified interpreters, trained to interpret from and into English and American Sign Language, are available. Ironically, some of the same institutions which accept the necessity, and are willing to

pay for quality interpreting services for Deaf patients do not recognize or pay for such services for non-English speaking patients.

The strategy to achieve the goals of training mental health professionals in language planning for interpreting and translating services includes the incorporation of (1) content on the subject of language barriers to communication, and, hence, quality patient care, (2) content on planned approaches to overcoming these barriers in professional training and (3) content on the responsibility of the professional to plan for and provide quality interpreting and translating services when they or their institution, clinic, or agency accepts a patient. This content belongs in all phases of training, from the beginning to the end. It can be included in components in course work on seemingly "unrelated" subjects, such as social work policy and psychopharmacotherapy, and in the more advanced levels in courses, seminars, workshops, and practica/field experiences.

An important element of this strategy will be the exposure of students to a real life experience observing interpreted communications of varying quality in cross-cultural mental health care early in their training. A workshop where role-playing or videotapes are used can be followed by a series of clinical observations. Reading can supplement but not supplant such an experience. This is especially important because few American students have any cross-cultural experience. Most are both monolingual and terribly naive about the seriousness of the problems presented by non-English speaking patients. Even those few who do have some cross-cultural skills are likely to be ignorant of the realities of the refugee experience. They need to be made aware of how devastating the language barrier can be to the prevention, diagnosis,

and treatment of mental health problems. Didactic material should provide information about the causes and categories of breakdowns in the communication process and prevention and repair strategies. This and subsequent training can provide students with communication techniques to deal with these barriers.

Content on language planning for refugee mental health care, difficulties of cross-cultural psychological assessment, and working with interpreters can be woven into curriculum in a systematic way. Introductory textbooks can include such material. Research from sociolinguistics, ethnography or communication/speaking, ethnolinguistics, and anthropology can be selected for incorporation into more advanced coursework. The growing literature on professional medical/mental health communication, both monolingual and across languages, uses conversation analysis, which studies the structure and coherence of linguistic interaction. The insights of this research can be used in didactic materials. A number of valuable papers on the use of interpreters in mental health care with the Deaf are already available. The Technical Assistance Center will be producing a task analysis of the interpreter in refugee mental health care using ethnographic observation and conversation analysis, as well as other materials for incorporation in professional mental health training and practice.

Reading and discussion must be complemented by experience and practice. Good quality videotapes of interpreted communication in mental health settings, with subtitles and transcripts, can be viewed and discussed for the purpose of becoming familiar with the breakdowns in understanding and repair strategies. It will be useful to have

tapes of good, mediocre, and poor quality interpreting. This will develop their understanding of the need for standards of quality in interpreting. Videotapes of interpreting by friends, relatives, fellow patients, inmates, housekeeping staff, and children will be useful in developing the students' understanding of the need for ethical standards regarding who may interpret. Videotapes of communication with refugee patients can prepare students for the special aspects of communication with these populations, e.g., gathering information about torture and escape experiences, concerns about family and clan members dead, lost, or left behind. Observation of role-playing and interpreted communication situation by a mental health professional, a trained interpreter and a "client/patient" may also be arranged. Those who may be doing cross-cultural assessment need specialized materials which focus in on the hazards of this work. Finally, with this advance preparation the students should have a range of clinical experiences with refugee clients in interpreted communication situations.

SOCIAL WORK

Students in this field at the BA level need coursework which covers planning for the difficulties presented by language and cultural barriers. Such coursework includes not only recognition of cultural differences but instruction, preparation and experience in working with interpreters and bilingual refugee paraprofessionals. Packaged "exercises" might be introduced, for example, role playing working through an interpreter (trained or untrained, competent or incompetent)

with refugee clients who need the services of a social agency. These exercises can prepare students for field experience.

At the BSW, MSW, and Ph.D. level, social work elective seminars, courses, and workshops with guest lecturers and practitioners in (1) the use of translators, translations, and interpreters in cross-cultural assessment in psychology and cross-cultural research for agency planning for social programs and (2) language planning in organizations and institutions should be offered for those who will be involved in assessment, needs analysis, and planning.

PSYCHIATRY

It appears that the competition for time and resources in the training of psychiatrists is fierce. The current trend is away from cross-cultural psychiatry in favor of biological psychiatry training. Despite this, knowledge of how to care for patients across cultures is increasing. Westermeyer (1985) assesses the situation in this way: "Currently our training programs and much of our clinical practice lag far behind the cross-cultural research findings, and demonstrated diagnostic techniques." We can expect fewer and fewer psychiatrists with, however, more and more knowledge in this area. What then should be the strategy to accomplish the goal of producing future generations of psychiatrists who will consider good quality interpreting and translating services as essential to ethical and successful patient/client care?

A three-pronged approach will be required. Material on working with interpreters can be incorporated in more general material on

communication with all patients and evaluating any patient's language for signs of illness, residents can be given clinical experiences with refugee patients who require interpreters, and material can be included in continuing education programs. For the majority of psychiatry students, it appears that little time in their long years of training will be devoted to cross-cultural psychiatry. It seems unlikely that the American Association of Directors of Psychiatric Residency Training statements in the 1984 Special Requirements that "the curriculum should . . . enable residents to render competent care to their patients from various cultural backgrounds" and that the residents "must have supervised experience in evaluation and treatment of patients . . . from a variety of ethnic, racial, social, and economic backgrounds" will be implemented.

Where then can residents learn about the reasons why interpreter services may be needed and how to work with interpreters? Two possibilities exist: these issues can be covered in the training material on communication with patients in general or they can be experienced in clinical settings. Professional interpreters and interpreter trainees (sign or spoken language) can provide the didactic material, since it is true that the medical and psychiatric faculty with expertise in this area are rare. In clinical settings the interpreters can assist the residents in understanding the linguistic dimensions of cross-cultural care and how best to use linguistic services. Most importantly the didactic and clinical material can prepare the residents to realize their own limitations in diagnosing and treating patients across cultural and linguistic barriers. Especially important, they need to learn that communicating with a

psychiatric patient in a language other than the patient's mother tongue, or with an incompetent interpreter such as a child, relative, or member of housekeeping staff, may appear to save time and money, but is actually misleading and may lead to dangerous and/or costly mistakes in diagnosis and treatment. Given the current situation as described by Jaranson, Moffic, and Westermeyer, it is unlikely that very many residents will ever actually be able "to render competent care to their patients from various cultural backgrounds." However, if their training contains enough material to sensitize them to the knowledge of their own limitations, they can be prepared to know what to do with such patients. Just as a primary health care physician refers a case he is not trained to care for to a specialist, psychiatric residents can be trained to recognize those patients they should refer to colleagues competent in cross-cultural psychiatry and knowledgeable about refugees. Finally, residents can be trained to expect that planning and provision of qualified interpreters is an essential part of the administrative policy of an institution, clinic or private practice which accepts the responsibility for care of those patients who are not English-speaking as well as the Deaf. They need to be trained to consider the provision of such services as a matter of ethics.

Those few students who wish to become competent in cross-cultural psychiatry could be given the opportunity to obtain a sub-specialty certification. As part of training in cross-cultural psychiatry, they would spend considerable time learning how to conduct assessment, diagnosis, and treatment across language and cultural barriers with the assistance of an interpreter. In particular they need to spend time

learning (1) about the psycholinguistic and emotional demands of the interpreting process; (2) about the interpreting profession so that they can distinguish quality services from inadequate services; (3) how to work successfully with an interpreter. The resident should have thorough familiarity with (1) the sociolinguistic literature on monolingual and cross-cultural doctor-patient communication; (2) the insights into the ethnography of communication, especially bilingualism and how that can contribute to evaluation of language factors in mental illness; (3) the emerging literature on interpreting for sign and spoken language in mental health care; (4) special aspects of interpreting for refugee patients. With such preparation they should be unlikely to evaluate such normal linguistic activity as code-switching (using both of the languages they speak in the same conversation in a rule-governed manner) and code-mixing (using both of the languages they speak in the same sentence in a rule-governed manner) as symptoms of mental illness, something which has happened in the past. They should be prepared for the transference phenomena which will focus upon the interpreter. And they should be sensitized to and prepared to deal productively with the power, control, and "ownership" issues which will accompany the interpreter's presence.

The third part of the strategy is to focus on the development of continuing education activities of all kinds, but especially activities such as courses and workshops for psychiatrists which provide the opportunity for hands-on experience communicating with patients through professional interpreters. The psychiatric profession needs to learn more about the advantages of working with interpreters who are trained. Finally it would be desirable for the minority of psychiatrists who are

concerned primarily with cross-cultural care to develop ties with those from the community of interpreters who are working or conducting research and training in mental health settings.

PSYCHOLOGY

One of the major emphases of content in coursework on refugee issues would be an introduction to recognizing language barriers and the need to planning for and using interpreting services in refugee mental health. Students need to see, through videotapes or clinical observation, how good communication can be when good interpreting services are available. Sections on professional ethics could develop the future professionals's obligation to recognize he or she cannot provide quality assessment or diagnosis in the absence of satisfactory communication with the client/patient or their adult family members. Later coursework should include preparation and practice in working through interpreters.

In psychology refugee mental health presents special problems. For example, approaches to the use of translated or interpreted tests, locally normed instruments, and alternative approaches to psychological assessment (including assessment for education purposes) when existing standardized tests are inappropriate, could be a topic of a seminar. In such a seminar content would include preparation for working with interpreters. Just as psychologists who deal with bilingual special education programs in the development of Individual Educational Plans for students must have this training, those who will be involved in the development of such plans for refugee children need additional training

to deal with the special problems of this population. Clinical training in conducting assessments with the assistance of an interpreter, as well as communicating with parents through an interpreter, is essential.

Since all models of the doctoral degree for psychology train professionals to work in settings where they are communicating with patients, or supervising those who do, they should be prepared to deal with language barriers appropriately, as described in the section on language planning content. If they plan to do research, either to obtain a degree or in their post-graduate employment, on refugee populations, they need additional coursework in anthropology, sociolinguistics, ethnography of communication/speaking, especially discourse analysis, and cross-cultural research methods, especially the use of translators and interpreters in research. This is essential to sensitize them to and train them to deal with the difficulties of designing and executing psychological and psychiatric research when different languages and cultures are involved.

NURSING

Content specific to refugee mental health should be included in psychiatric mental health content and this could build on general concepts of transcultural and ethnic nursing.

Since nurses are entrusted with the moment-to-moment care of patients, they will have most of the quantity of communication with them and their families, they will have the most opportunities to confront the language barrier. They will frequently conduct the first

intake interview, and in some situations, even make the initial face-to-face or telephone contact with the patient. They can be trained to alert the rest of the staff that interpreting services need to be provided for a particular patient and family. They will frequently be the first in a team to witness an event, such as a patient's change of condition or a family's uncertainty about care, that needs to be (1) noticed (2) reported accurately (3) understood or investigated further and (4) handled appropriately. Without (1) cross-cultural sensitivity and (2) an interpreter they may not even perceive such an event or change. In some inpatient settings they will be responsible for administering assessment instruments to monitor a patient's condition. For all of these reasons they need to be trained to work with interpreters. Those who will become administrators and supervisors and may eventually have wider responsibilities need to be introduced to the concepts of language planning for medical and mental health settings in institutions, agencies, clinics, and private practices.

PHYSICAL THERAPY

Physical therapists need essentially the same course content vis a vis interpreting and translating services as nurses, with the following additional preparation for the clinical experience of working with an interpreter as they assist in the therapy of refugee patients. They need to be sensitized to the cultural/linguistic aspects of body movement, body language, and body conceptualization, as well as the cultural/linguistic specific concepts of handicapping conditions,

disease, illness, aging, and rehabilitatio as part of their preparation to work with the patients and interpreters: some surprises may be in store for them. They cannot proceed as they would with patients of their own culture and language. Without this preparation, communication may be poor, and therapy unsuccessful, even with a skilled interpreter.

Center for Refugee Ethnography

An academic program providing access to refugee cultures through ethnographic research, confererces, course work, and materials.

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DIVISION OF GRADUATE & CONTINUING STUDIES
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THE FOCUS:

What is Ethnography?

Ethnography is the study of culture. It is holistic in nature, searching for linkages among seemingly disparate facets of human behavior—family organization, religious beliefs, economic exchange, and political structure. It leads to an understanding of rules and codes by which group members enact basic values and set themselves apart from non-members. It employs the language of social science but also seeks to understand the world from the perspectives of its subjects, the ways in which they categorize the world and think about it, their strategies for action. Moreover, ethnographic studies do not assume that culture groups are homogenous. We observe the dialectic in which both individuals and society create ideational and stylistic models for action as culture changes.

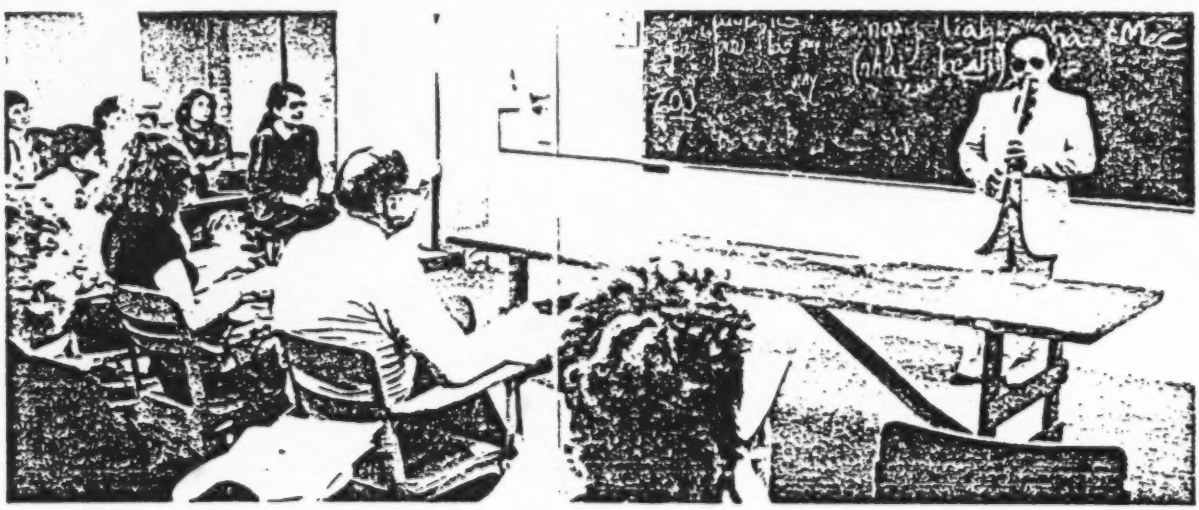
THE CHALLENGE:

Why a Center for Refugee Ethnography?

In 1975, Minnesota began to experience a dramatic influx of refugees from various parts of Southeast Asia and other Third World countries. These refugees, and especially their school-aged children, have presented distinct challenges to teachers, public assistance programs, and other support agencies.

The Center for Refugee Ethnography seeks to help you understand the complex socio-cultural heritage which refugees bring to their new life and which they continue to draw upon for basic values and expression. Increased cultural awareness will enhance your ability to teach them skills—primarily language and literacy—and to help them become self-sufficient within the mainstream of American life.

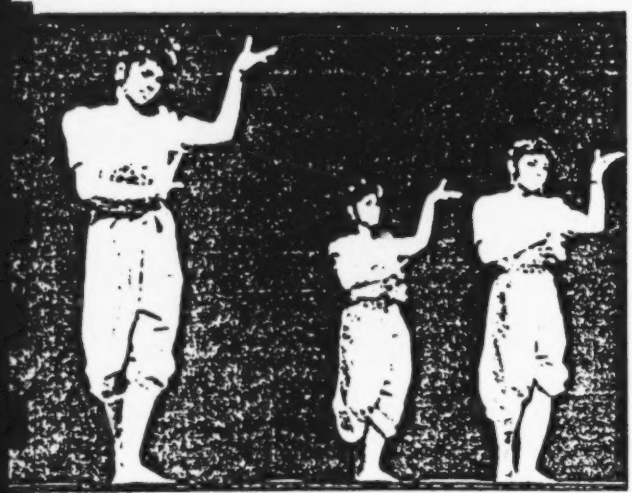
It is vital to understand their culture as we begin to teach them ours.



[I]R PURPOSE:

Access to Refugee [c]ultures and Languages.

The Center for Refugee Ethnography is a new [p]rogram. Our course offerings are an unusual [o]pportunity to study all important aspects of [r]efugee life. Through the study of current research and contact with representatives of [t]he refugee communities, students attain a more [s]ophisticated approach to Minnesota's newest peoples.



[O]ur introductory courses provide a survey of traditional life as experienced in the country [o]f origin and in the resettlement community. [S]pecial emphases are given to history, social [s]tructure, spiritual expression, visual and [p]erforming arts, food customs, sickness and [h]ealing, and the traditional values with which [t]he community most readily identifies itself.

Advanced seminars address specific topics [g]ermane to current life in refugee communities, [s]uch as mental health, legal conflicts, learning and literacy problems, preservation and changes [i]n religious life, and new adjustments in social [o]rganization.

The Center is intended to respond directly to the needs of social, educational, and health services professionals. In the near future, additional courses will be initiated, such as intensive summer language instruction, surveys of other refugee cultures, or courses on specific topics. You can help in this effort by indicating your course needs on the information request card.

The Center for Refugee Ethnography lists courses in the regular Fall, Spring, and Summer bulletins issued by the Division of Graduate and Continuing Studies, Hamline University.

For further information call: (612) 641-2900.

INFORMATION REQUEST CARD

Name _____

Street/PO _____

City/State/Zip _____

(_____) _____ (_____) _____
Telephone/day Telephone/eve message

Highest academic degree earned _____

Area of professional interest _____

_____

I am interested in:

☐ *Summer courses* ☐ *Fall/Spring courses*

Refugee cultures:
☐ Cambodian ☐ Thai
☐ Hmong ☐ Laotian
☐ Vietnamese

☐ Other _____

Refugee languages:
☐ Khmer ☐ Thai
☐ Hmong ☐ Laotian
☐ Vietnamese

☐ Other _____

Anthropology

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h 620
fron and Gold:
Introduction to Cambodian
nguage and Symbolic Behavior

odians are rapidly becoming a significant refugee sion in urban Minnesota. They bring both an ancient al heritage and harsh experiences from recent military and al upheaval. Their background presents unique challenges sroom teachers.

dits. Enrollment limit: 30. Five sessions: Tuesdays, 5:30- p.m., October 6, 13, 20, 27 & November 3. Learning er 108W.

course acquaints you with contemporary mbodian life as experienced by refugees, both ore immigration and after resettlement in the . The course goal is a functional understanding raditional values and images that influence ssroom behavior and learning. You learn of Khmer approach to Buddhism which uences the way in which ancient legends nd with recorded history to provide mbodians with a distinct image of themselves modern world. Among topics covered are dualistic nature of traditional Khmer social ucture and family expectations, festivals and annual cycle, healing and the spirit world, stume, story telling, and music. Native eakers will demonstrate the basic structure of mer language and how that language has anged since the revolution of the 1970's. This urse features an evening meal of traditional ds, hosted by local Cambodian families. rget audience: teachers K-12 (social studies d ESL teachers should find this course pecially interesting). Cost: $165.

ructor/coordinator: *Willard B. Moore is a folklorist with ng preparation and experience in cultural anthropology. A mer high school teacher, Bill now directs Hamline's Center for ugee Ethnography. He has resided in Minnesota since 1978 d has been involved in a number of projects documenting nic and regional traditions, including a survey of Minnesota's h area and co-authorship of The Minnesota Ethnic Food ok (1984).*

Anth 622 (formerly ModL 701)
An Introduction to Hmong Language and Symbolic Behavior

The Hmong of Laos are a unique group, having maintained much of their traditional folk culture in the midst of the American urban environment. Public school teachers have received resource materials about the Hmong people in Minnesota for the purposes of cultural understanding and more effective teaching of this new minority. Unfortunately, teachers' resource materials have emphasized historical, political and demographic information about the Hmong as a refugee group. The course provides an introduction to the culture of the Hmong as an ethnic group.

2 credits. Enrollment limit: 30. Four sessions: Monday-Thursday, 12:30-8:20 p.m. plus a special Wednesday evening meal, June 27-July 2. LC106W.

Going beyond a superficial cultural profile, this course provides an analysis of the Hmong language, major Hmong cultural elements and the relationships among these elements. You trace the influence of native language and culture on the behavior of Hmong children in the classroom and the community. Native speakers and practitioners demonstrate language and interpret cultural elements. Among the topics covered are social structure, myths and folk stories, music, food and foodways, religious and spiritual beliefs, artistic characteristics of material culture. Among the highlights will be simulated experiences of cultures in conflict, and a special evening meal hosted by five local Hmong families. Target audience: teachers K-12 (social studies and ESL teachers should find this course to be especially interesting). Cost: $165.

Instructor/coordinators: Willard Moore. See biographical sketch under Anth 620. Joanne Blake, a Minneapolis educational consultant, who, over the past five years has become fluent in Hmong and has lived among the Hmong in Thailand both in refugee camps and in free mountain villages. She is thoroughly familiar with the Hmong enclaves in the Twin Cities, Rochester and several smaller Minnesota communities.

Anth 624

Hmong Language and Culture II

More available research materials and a wide demand by teachers to learn about the Hmong refugees determines our expansion of the original course to a second-level program this summer. The growing Hmong school population continues to experience social, economic, and educational problems which will be closely examined through a variety of learning techniques.

2 credits. Enrollment limit: 30. Four sessions: Monday-Thursday, 12:30-8:20 p.m., July 6-July 9. LC106W.

This continuing course, "Pepper Eaters II" gives special attention to topics crucial to understanding the life of Hmong people as they move from the status of refugees toward "ethnics." Major topics include the conflicts between traditional behavior and American legal practices (especially in family and courtship behavior), the influence of family planning and SDS (Sudden Death Syndrome) and other stress related phenomena on family and community life, changes in Hmong music and artistic expression, the confluence of Christianity and traditional Hmong beliefs as they are expressed in myths and in modern legends, and a history of Hmong farming and other employment patterns since immigration. Selected readings provide historical background and describe the Hmong position in the context of Southeast Asian political conflicts. Native speakers and interpreters will provide commentary and answer questions. Target audience: ESL, L.E.P., and other teachers K-12, health care personnel, minority group advocates. Cost: $160.

Instructor: Willard Moore. See biographical sketch under Anth 620.

Anth 626
The Land of a Million Elephants: Introduction to Laotian Culture and Language

The lowland Lao refugee community in Minnesota is quite distinct from the Hmong and other hill tribes which have historically resided in Laos. Their political history and relationship to neighboring Vietnam, the influence of Buddhist belief on daily life, and their expressive behaviors, especially in music, give them an identity which teachers, health maintenance personnel, and refugee program workers will enjoy learning about.

2 credits. Enrollment limit: 30. Five Sessions: Wednesdays, 6:00-9:30 p.m., February 3, 17, March 2, 16 & April 6. Plus a Lao dinner; time to be announced.

This course explores the history of Laos in the context of China and recent developments in Southeast Asia, including the influence of Vietnam and the rise of the Pathet Lao. The class will cover traditional lowland Lao life in all its rich and complex aspects: religious life and its influence upon the family, the community, and the world view of individuals in modern times; traditional arts; literature and oral traditions; the Laotian attitude toward food and their uses of food as symbols; and the pattern of Lao life in Minnesota, with special emphases on children in the public school. Well-informed members of the Lao community will serve as guest speakers and resource persons, offering direct contact with community values and a brief introduction to Lao language (spoken and written). Students will prepare reading assignments and participate in lectures, demonstrations, and discussions. As usual with introductory courses, an authentic Lao dinner will be scheduled during the course as part of the learning experience. Target audience: teachers K-12. Cost: $165.

Instructor: Willard B. Moore. See biographical sketch under Anth 620.

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Hamline University
1536 Hewitt Avenue
St. Paul, MN 55104

Who are our Students?

- An **ESL teacher** who has twice visited refugee camps in Thailand and teaches classes in which Hmong children are the majority.
- A **Hmong-American teacher** who immigrated with his parents at age seven and had forgotten most of the traditional aspects of his heritage.
- A **public health nurse** who sees more Southeast Asian patients than any other ethnic group
- A **social worker** in Wisconsin whose case load is made up entirely of Southeast Asian refugees, mainly Hmong.
- An **LEP teacher** of recently arrived Cambodian children who is challenged by their inability to identify colors and animals by name, even in their own language.

The Center's program is designed primarily for working professionals as

- in-service workshops by special arrangement
- part of ongoing professional development
- course work leading to a graduate degree.

Other Professional Learning Opportunities

From time to time, the Center for Refugee Ethnography will plan and present conferences linking refugee studies with special educational issues. The basis for conference programming will be

- the Center's ongoing research to update curriculum materials,
- frequent interaction with the refugee communities and with other scholars, and
- innovations in classroom methodology for refugee children and adults.